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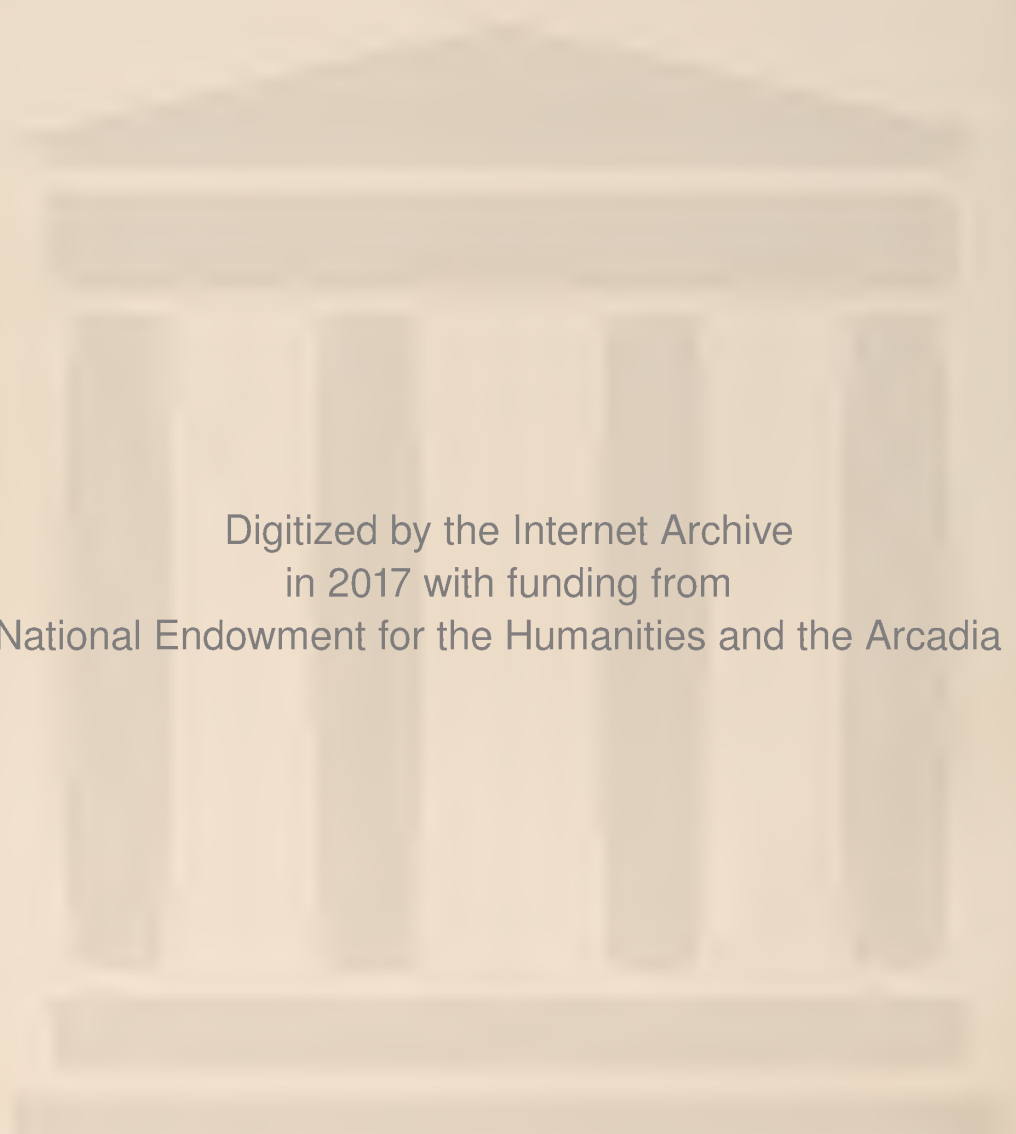












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# RHODE ISLAND



JANUARY, 1959

## Medical Journal

42  
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Volume XLII, No. 1

Table of Contents, page 11

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**REFERENCES:** (1) Holloway, W. J., & Scott, E. G.: *Delaware M. J.* 30:175, 1958. (2) Roy, T. E., et al.: *Canad. M. J.* 77:844, 1957. (3) Markham, N. P., & Shott, H. C. W.: *New Zealand M. J.* 57:55, 1958. (4) Royer, A., in Welch, H. Marti-Ibañez, E.: *Antibiotics Annual 1957-1958*, New York, Medical Encyclopedia, Inc., 1958, p. 783. (5) Blair, J., & Carr, M.: *J.A.M.A.* 166:1192, 1958. (6) Caswell, H. T., et al.: *Surg., Gynec. & Obst.* 106:1, 1958. (7) Fekety, F., et al.: *Am. J. Pub. Health* 48:298, 1958. (8) Godfrey, M. E., & Smith, I. M.: *J.A.M.A.* 166:1197, 1958. (9) Kessler, A., & Scott, R. B.: *J. Dis. Child.* 96:294, 1958. (10) Shaffer, T. E.: *J. Michigan M. Soc.* 57:851, 1958.

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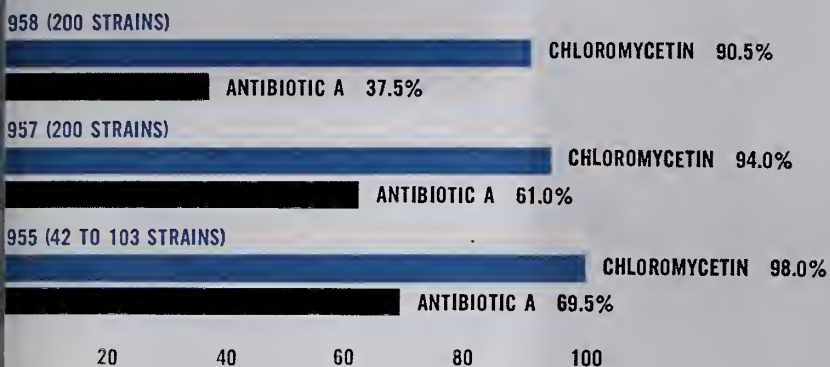
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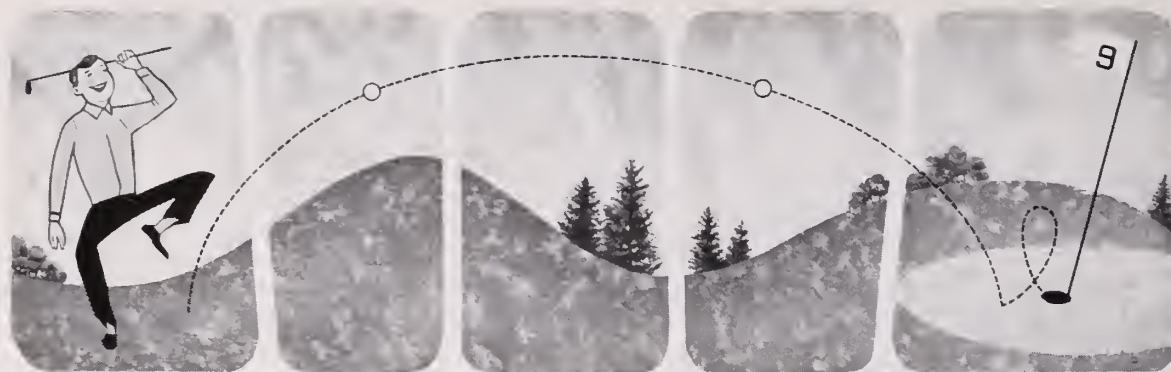
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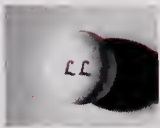
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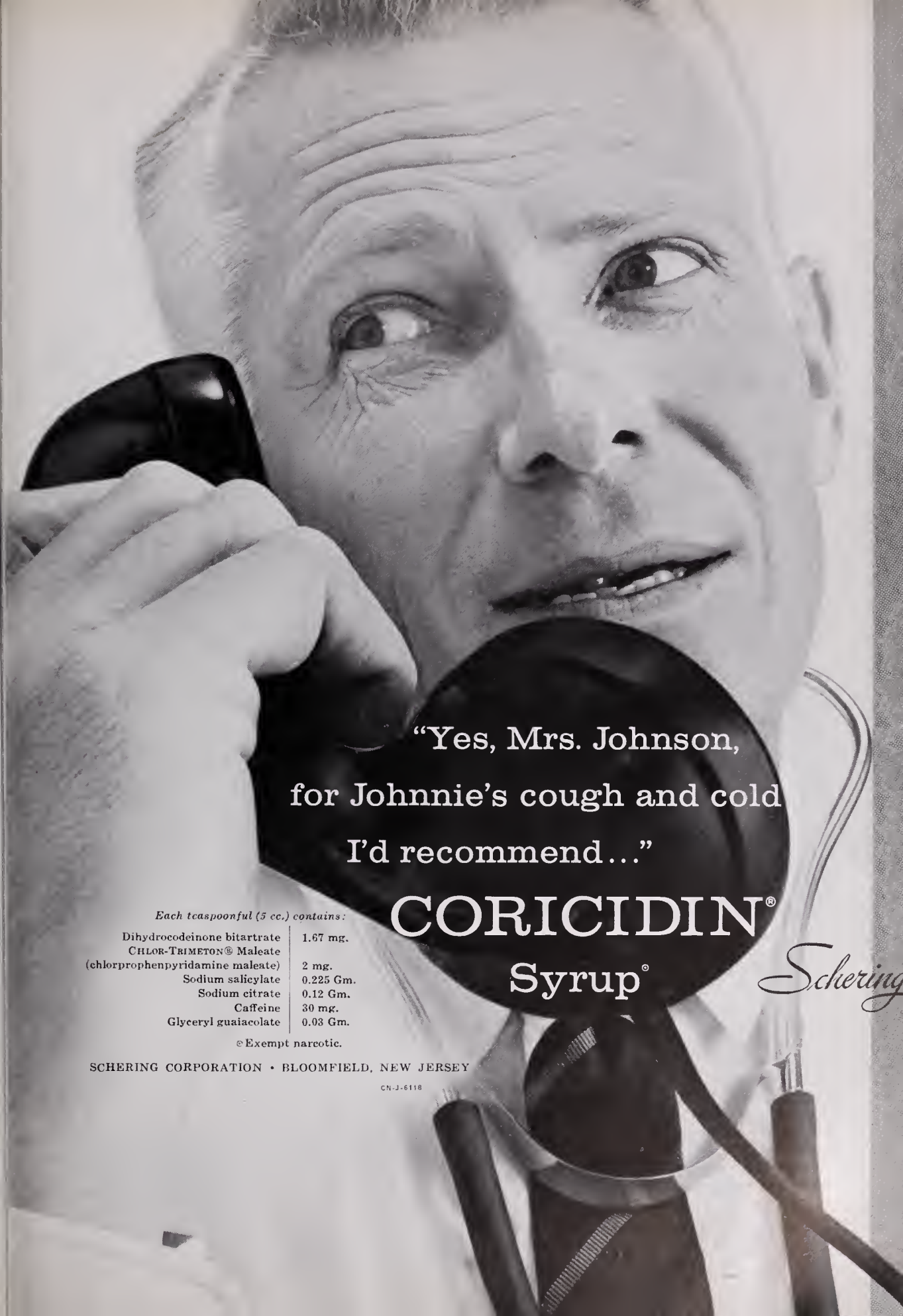
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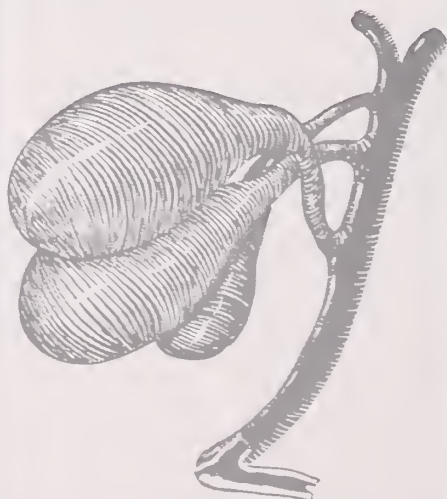
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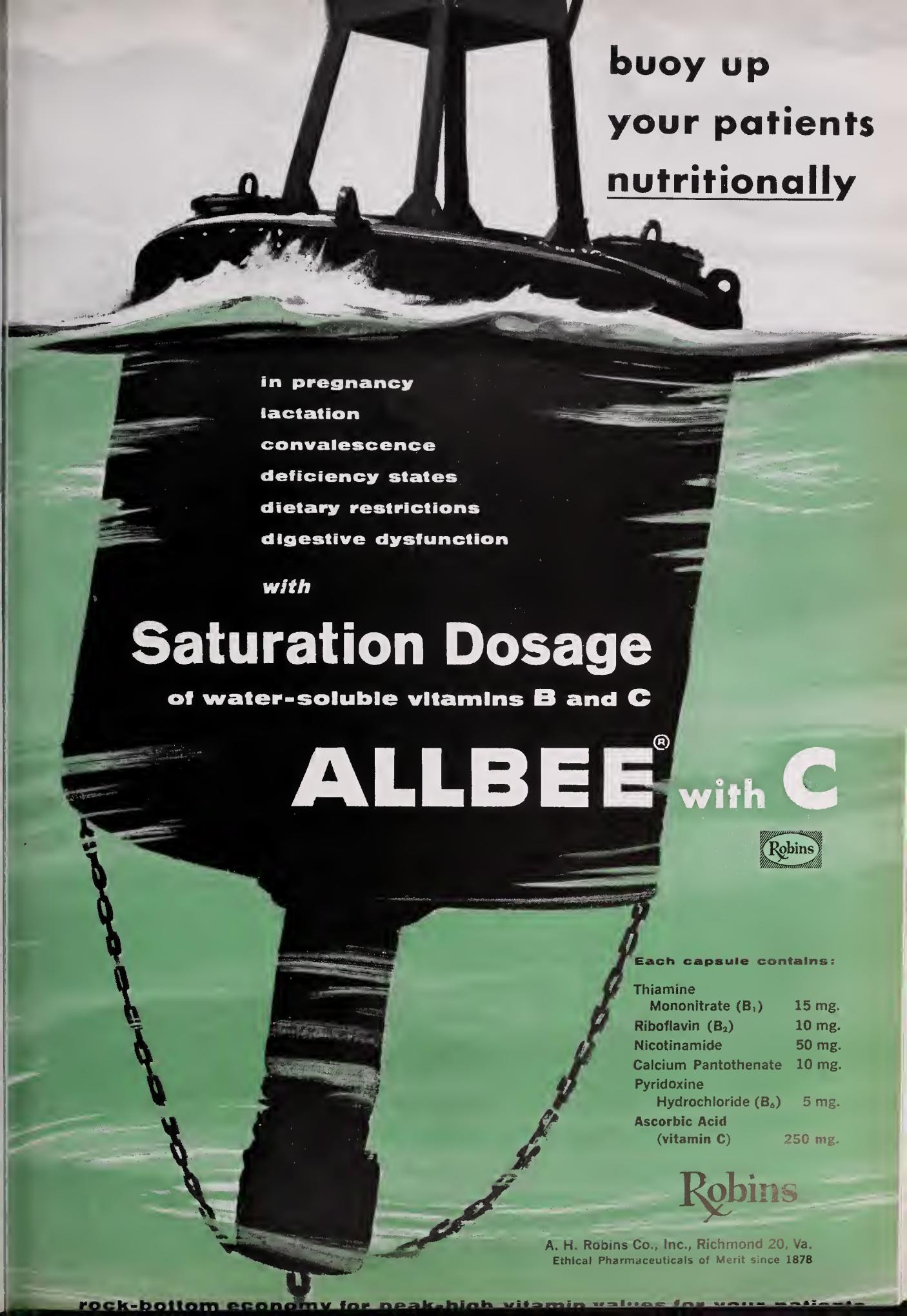
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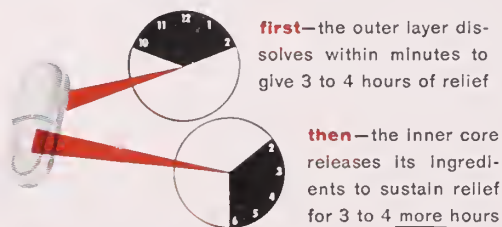
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## *The Eleventh Dr. Isaac Gerber Oration—*

### SOME INFLUENCES OF THE INTRACRANIAL CONTENTS ON THE ROENTGEN APPEARANCE OF THE SKULL\*

LEO M. DAVIDOFF, M.D.

The Author, *Leo M. Davidoff, M.D., of New York, New York, Professor and Chairman of the Department of Surgery, Albert Einstein College of Medicine, New York, New York.*

MOST OF US think of the skull in terms of the prepared dry specimens we used in school, in the course in osteology, and find it difficult to visualize this hard and brittle material being influenced in any way by the soft, jelly-like contents of the cranial cavity. I ask you only to imagine yourselves drifting down the Colorado River in a canoe and gazing up along the walls of the Grand Canyon. Just remember that this mile-deep incision in the earth's surface was made by the limpid, yielding water that runs between the fingers of your hand. Indeed, the study of the skeletal system by roentgenography has considerable similarity to the study of the earth's crust by geological methods. In both instances the story of past events may be read from present appearances by those who are literate in the specific language in which the tale is written.

The growth of the skull, even though more complicated, takes place in accordance with the same principles as the growth of other bones in the skeleton. It was John Hunter, in his classical treatise on *The Natural History of the Human Teeth* in 1771, who pointed out that, among other things, resorption of bone must be as characteristic of growth as deposition, or else bones would become too massive and heavy for economical management. Even earlier in the 18th Century, Belchier (1736) and Duhamel (1739) fed yellow madder to young animals to stain their bones at a given age, and then measured the unstained parts of the bones in adult life to indicate the direction and quantity of growth.

Brodie (1941),<sup>1</sup> utilizing the superb collection of skull roentgenograms made under the direction of the late Professor T. Wingate Todd at Western Reserve University, produced remarkably graphic evidence illustrating this principle by roentgenography. By superimposing the skull X rays of the

same child taken at frequent intervals from three months to eight years of age, he showed that while the general shape of the skull remained essentially unchanged, the size increased concentrically, obviously by the absorption of the inner table and the deposition of bone on the outer table. (Figure 1)

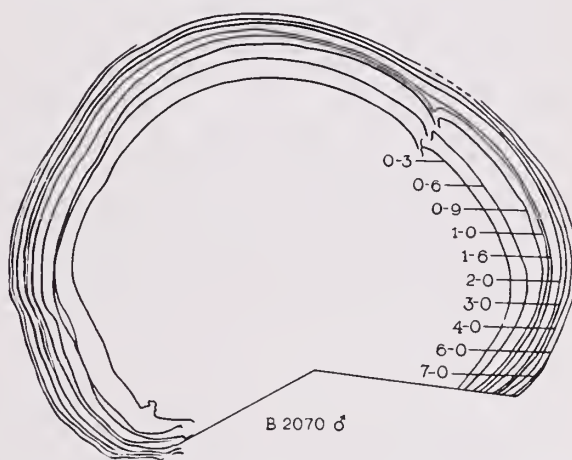


FIGURE I

Reproduction from Brodie\* (Fig. 5, page 232), showing the superimposed outlines of the skull of the same child from three months to eight years of age.

\*Reproduced with kind permission of Dr. Brodie.

It seems logical to assume that the stimulus to growth of the skull, is the maintenance of a slight degree of positive pressure contributed by the growing brain. Indeed, convolutional "markings" or "impressions" are present in normal children's skulls when viewed on the roentgenogram, indicating irregular thinning of the skull. This can be confirmed at post-mortem examination by holding up the removed calvarium toward a bright light. Because of the irregular surface of the brain, it is assumed that the pressure is greater over the apex of the cerebral convolutions than over the sulci, and that this thinning is in response to cerebral growth.

It was the privilege of the essayist,<sup>2</sup> twenty-odd years ago, to spend some time at Western Reserve University examining the collection of skull roentgenograms of normal children ranging in age from three months to eighteen years, in the collection already mentioned of Professor T. Wingate Todd. An arbitrary scale from + to 6+ was established

*continued on next page*

\*The Eleventh Annual Doctor Isaac Gerber Oration delivered at the Miriam Hospital, Providence, Rhode Island, October 15, 1958, under the sponsorship of the Miriam Hospital Staff Association.

to indicate the depth of convolutional markings, as seen in the lateral skull roentgenograms. A total of 2500 films were reviewed. The results revealed:

1. No convolutional markings were seen before nine months of age, and very few before eighteen months of age.

2. After one and one-half years, the markings increased very rapidly up to four years of age, then continued at this high level until between seven and nine years of age.

3. After nine years of age the number and depth of the markings diminishes progressively until fourteen years of age.

4. From this point on the disappearance of convolutional markings was halted, and indeed a slight increase occurred up to eighteen years of age, when the study was interrupted.

The absence of convolutional markings before one and one-half years is understandable on the basis of the widely open skull sutures up to this age, which must yield to pressure sooner and more readily than the inner table. After infancy, however, if the convolutional markings are indeed a reflection in the skull of the growth of the brain, some correlation should be demonstrable between the curve of growth of the brain and the number and depth of the markings. This correlation is seen in the superimposed curves in the above illustration resulting from our study. (Figure II)

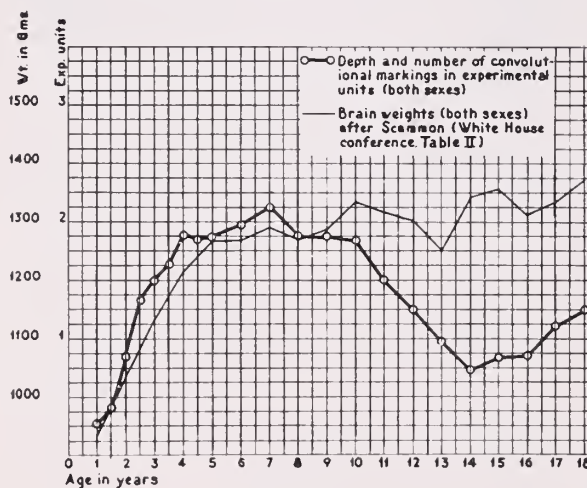


FIGURE II

Showing a comparison of the convolutional markings curve in terms of experimental units with the weight of the brain in grams; Ages 1 to 18.

Known exaggerated states of intracranial pressure, especially in children, as seen for example in cases of obstructive hydrocephalus, may show not only an increased degree of convolutional markings, but separation of the cranial sutures, atrophy of the sella turcica, and even abnormal enlargement of the whole head.

In the case of a child<sup>3</sup> whose obstructive hydro-

cephalus was due to a tumor of the cerebellum, we had an unusual opportunity to observe these phenomena waxing and waning with variations in pressure. When first seen at the age of seven years, her skull roentgenograms showed a severe degree of convolutional impressions, widely separated sutures, and marked atrophy of the sella turcica. She was then operated upon, the tumor was removed, and five and one-half months later the abnormal convolutional markings were erased, the sutures were almost closed, and the sella turcica became recalcified. She was well for ten months, then gradually began to show signs of recurrence of the tumor. Seven months after the return of symptoms, repeat skull X rays again showed increased convolutional markings, separation of sutures, and sellar atrophy. She was re-operated upon, and eleven months after the second operation the child was clinically well and the roentgen signs had again disappeared.

On reflection it is perhaps not so strange to learn that the growth of the skull is secondary to the growth of the brain, and that the same mechanism utilized by the skull in response to the slow steady pressure of normal cerebral growth is also employed in response to the greater and more rapidly developing pressure resulting from space occupying, or obstructing intracranial lesions.

On the other hand, it was somewhat surprising to discover that if one hemisphere of the brain should have its growth interrupted, the normal side continues to show the usual response to growth, whereas the abnormal side shows a reversal of the direction—a sort of inward directed, growth in order for the skull to conform to the diminished mass of the involved cerebral hemisphere.

In 1933, together with Cornelius G. Dyke and Clement B. Masson,<sup>4</sup> the speaker presented the case histories, along with the radiologic appearance of the skull, in nine cases of "infantile hemiplegias"; that is, grown children or adults with hemiplegia existing since infancy. The roentgenograms of the skull in these cases revealed a thickening of the cranial vault on the same side as the cerebral lesion and also an overdevelopment of the frontal and ethmoid sinuses and of the air cells of the petrous pyramid. (Figure III) The changes in the bone occur very slowly, as evidenced by the slight thickening present in our two youngest patients (eight and nine years). The response of the skull to cerebral hemiatrophy is thus analogous to the changes in the chest following chronic empyema. The intercostal spaces decrease by approximation of the ribs to each other. The diaphragm on the affected side becomes elevated, and the mediastinum becomes displaced toward it, thus diminishing the capacity of the half of the chest which houses the collapsed lung.





FIGURE III

Antero-posterior roentgenogram of the skull from a case of right infantile hemiplegia showing thickening of the left half of the calvarium, enlargement of the left frontal and ethmoidal sinuses, and diminution of the size of the left half of the intracranial cavity.

One local effect from generalized increase of intracranial pressure is atrophy of the sella turcica. This has already been referred to in the case that was cited above, of the little girl with the cerebellar tumor. The exact mechanism for this is not altogether clear. One is tempted again to invoke the analogy between our subject and a flowing river. I am sure that everyone who has lived in familiar proximity to a river has observed that a boulder sticking up in mid-stream is worn away by the water to a greater degree than the rocks that line the shores. However it happens, we know that sellar atrophy takes time, before it becomes evident on the roentgenogram. How much time one cannot be certain, but it must be somewhere in the order of six months as a minimum. One seldom sees it, for example, in patients with very rapidly growing primary or metastatic malignant brain tumors. Thus its disclosure on the roentgenogram is not only indicative of increased intracranial pressure, but suggests the presence of a relatively slowly developing, and therefore perhaps relatively benign lesion. As a practical point, one should avoid the error of interpreting the demineralization of the sella turcica that one may see in people past middle life, for atrophy of the sella due to increased intracranial pressure. (Figure IV) As a second precaution, one should avoid calling the local atrophy of the sella turcica due to a pituitary tumor as merely

an indication of generalized increased intracranial pressure.

In addition to changes in the skull resulting from generalized increase in intracranial pressure, evidence of local pressure may be seen in response to slowly growing intracranial lesions located adjacent to the inner walls of the intracranial cavity. A somewhat special example of this response is the enlargement and atrophy of the sella turcica that one sees in cases of intrasellar tumors originating in the pituitary gland just mentioned. The distinguishing point is the *enlargement* as well as the atrophy that takes place with a tumor of the hypophysis, as contrasted to the atrophy alone when it is due to generalized pressure.

In cases of neurinomas of the acoustic nerve, which usually arise from the portion of the sheath of this nerve within the internal acoustic meatus, atrophy and erosion of the tip of the petrous bone may often be demonstrated. In these cases, since the tumor sooner or later reaches sufficient size to produce obstruction to the exit of cerebrospinal fluid from the fourth ventricle with resultant increase in intracranial pressure, one often sees both local atrophy of the petrous tip due to the neighboring tumor, and atrophy of the sella turcica due to generalized increase in intracranial pressure.

Local thinning of the temporal or parietal bone may sometimes be seen produced by slowly growing gliomas involving the cortex of the brain adjacent to the inner table of the skull.

An interesting example of the effects of local pressure on the skull by a non-neoplastic lesion is sometimes seen in patients, especially children, who have suffered a linear fracture of the skull with

*concluded on next page*



FIGURE IV

Lateral roentgenogram of the skull in a 78-year-old woman showing demineralization of the sella turcica associated with aging.

adjacent trauma to the brain. Under these circumstances adhesions may form, involving the leptomeninges. These adhesions may then trap cerebrospinal fluid which is prevented from leaving the area, and may accumulate in sufficient quantity to produce localized increase of pressure (a leptomeningeal cyst). The result is that the gap between the margins of the fracture, instead of healing with bone, is gradually widened and the margins themselves become thin and irregular. (Figure V)

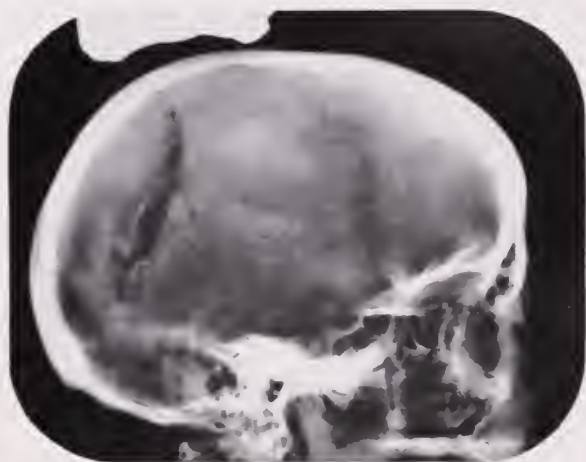


FIGURE V

Lateral skull roentgenogram showing widening of linear skull fracture.

A fascinating experience with a hitherto undescribed example of local skull changes produced by a neighboring intracranial lesion was reported in 1938<sup>5</sup> by Dr. Dyke and myself, and is worthy of recalling to your attention. This concerned the cases of four young people, ranging in age from six to eighteen years. They came to us because of cerebral symptoms, primarily of headache and vomiting, with a history of recently preceding trauma, occurring from two to twelve months prior to admission. In each case there was also a history of earlier trauma to the head, from five to eleven years prior to admission.

One patient, on physical examination, showed an enlarged head; another a localized protrusion of the right fronto-temporal region of the skull, with ipsilateral exophthalmos. On plain skull roentgenograms in all the patients a variety of localized changes were noted, although not all the cases showed all the changes. These were:

1. Elevation of the sphenoid ridge, superior orbital plate and superior orbital ridge.
2. Deepening, widening, and lengthening of the middle fossa.
3. Disappearance of the oblique line delineating the posterolateral wall of the bony orbit.
4. Atrophy of the inferior and lateral wall of the superior orbital fissure.

5. Hypertrophy of the frontal and ethmoidal sinuses.

6. Thickening of the skull.

In each case a chronic subdural hematoma was found at operation at the site of the localized skull changes. Since obviously the interval between the more recent trauma and hospital admission was too short for the skull changes to have taken place from local pressure of a fresh subdural hematoma, we were led to conclude that the hematoma was the result of the earlier trauma. We reasoned that the skull reacted to the accumulated subdural blood in the five- to eleven-year interval. The more recent trauma produced further bleeding, with resulting symptoms leading to the hospitalization and operation. We referred to the condition as "relapsing juvenile chronic subdural hematoma"—a rather cumbersome name. We have seen a number of additional cases of this kind in the past twenty years, and others have confirmed our observations.

Time does not permit me to recite many other remarkable examples of the effects upon the skull of changes taking place within its vaulted chamber. However, even from these few selected examples, we learn that we may find "... books in running brooks, sermons in stones, and good in everything."

#### REFERENCES

- <sup>1</sup>Brodie, Allan G.: "On the Growth Pattern of the Human Head From the Third Month to the Eighth Year of Life." *Am. Jour. Anatomy*; 68:209-262, 1941
- <sup>2</sup>Davidoff, Leo M.: "Convolutional Digitations Seen in the Roentgenograms of Immature Human Skulls." *Bull. Neurological Institute of New York*; 5:61-71, 1936
- <sup>3</sup>Davidoff, Leo M.: "Variations in Intracranial Pressure Revealed by the Roentgenographic Appearance of the Skull." *Emanuel Libman Anniversary Volumes*; 1:357-362, 1932
- <sup>4</sup>Dyke, Cornelius G.; Davidoff, Leo M.; and Masson, Clement B.: "Cerebral Hemiatrophy with Homolateral Hypertrophy of the Skull and Sinuses." *Surgery, Gynecology and Obstetrics*; 57:588-600, 1933
- <sup>5</sup>Davidoff, Leo M.; and Dyke, Cornelius G.: "Relapsing Juvenile Chronic Subdural Hematoma—A Clinical and Roentgenographic Study." *Bull. Neurological Institute of New York*; 7:95-111, 1938

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## THE GEORGE MEMORIAL BUILDING AT RHODE ISLAND HOSPITAL\*

SHIELDS WARREN, M.D.

The Author, *Shields Warren, M.D., of Boston, Massachusetts, Pathologist, New England Deaconess Hospital; Professor of Pathology, Harvard Medical School; Member, Executive Committee, Division of Medical Sciences, National Research Council; Charles V. Chapin Orator of Rhode Island Medical Society, 1958.*

WE ARE ACCUSTOMED to speak in these fast-changing days in terms of the atomic age, the space age, but these are only short periods in the age of science. The first glimmering of this age showed in the erection of the pyramids, in the astronomical observations of the Mayans, in the laws of Newton, in the periodic table of elements. However, the onrush of science has been so rapid in the last fifty years that students of history point out that 90 per cent of the scientists that ever lived are alive and working today. Scientific effort has been doubled two or three times in a generation. A McGraw-Hill survey estimates that in this year American industry is spending eight billion dollars for science and technology.

Daniel F. George, to whom we owe this new building and the means for its continued use, saw this vision of the rapid advance of science and further saw that science must be made to serve rather than overwhelm humanity. With this clear vision, he established the Mary Jane Bennett Hubbell George and Annie Robina Brisbane Roy Miller Memorial and Fund. This vision focused sharply on cancer as one of the greatest enemies of mankind. This building that we are dedicating today is to be devoted to the diagnosis, care and treatment of persons suffering from cancer and even more importantly to research in cancer.

The Rhode Island Hospital has a long and distinguished record in healing of the sick. Its staff pioneered in the struggle against cancer and from the beginning of organized efforts against cancer in this country has played a continuing and significant part. In this struggle against cancer, it is fortunate in having a sister institution—Brown University—that is now one of the active and effective centers in

the basic aspects of cancer research. It is further fortunate in having in the Rhode Island Division of the American Cancer Society an effective unit of the great lay movement against cancer and another strong partner in the attack on cancer in Rhode Island.

Effective care of patients hinges on bringing a variety of professional skills to focus on the immediate needs of the patient. It depends on education, both in the prevention and control of disease and to insure a future supply of those practicing the healing arts. It depends on research to push back ignorance. It needs all these tempered by humanity. This community is truly fortunate to have as a new and significant guardian against cancer this George Memorial with its well-balanced facilities and program to meet these needs.

Cancer is not an abstract thing. It is a disease multiple in its manifestations, disastrous in its ravages, treacherous in its attack.

How does one go about countering it? The ways are many. Scientists all over the world, whether it be India, Russia or Rhode Island, are working to overcome it. When one brings a new unit into the attack, it is important that this unit be so disposed as to have the greatest effectiveness possible. This has been clearly realized by the Trustees of the Rhode Island Hospital and years of thought have gone into the determination of how best the vision of Daniel F. George can be translated into an effective weapon for mankind. Medical research is going on at a tremendous scale in this country, perhaps above all others. This year some 300,000,000 dollars are being spent on various aspects of medical research and a major portion of this on cancer. Nearly three fifths of this huge sum is made available through governmental channels. All of us realize the urgency of the struggle against disease and particularly against cancer.

What will be the particular mission of the George Memorial? No one can see clearly far into the future. Nonetheless, general guides are apparent. First, the caliber of patient care at the Rhode Island Hospital is excellent. So strength is more needed in research aspects than in clinical. Second, cancer research moves irregularly and in varied directions as new facts are uncovered. The areas in which there appear to be greatest promise at the present

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\*Address at the cornerstone ceremony of the George Building at Rhode Island Hospital, at Providence, Rhode Island, October 26, 1958.

time are those of the medical approach to cancer: utilization of the powerful hormones that control so many of the activities of our body's cells; chemotherapy—the use of chemical substances to control different types of cancer particularly leukemia; and research in hematology, where the relationship of diseases of cells of the blood to the total cancer problem have been of great significance. The relation of viruses to cancer treatment is still remote.

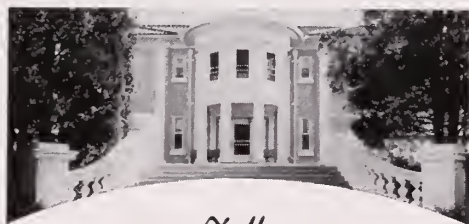
The development of new ideas is the best way for any one research group to be effective in the field of chemotherapy. Simply adding to the total facilities for the screening for therapeutic efficacy of the multitude of substances now available is hardly sufficiently significant or encouraging to warrant following this direction. Approximately 25,000 chemicals and biologic products are annually furnished to the Service Center of the National Cancer Institute of the National Institutes of Health alone by the pharmaceutical industry and university laboratories. This field, though important, appears adequately covered and the efforts of the George Memorial would not add materially to it. However, from time to time important breakthroughs do occur, and we could look to the staff of this unit to bring these promptly to bear for the benefit of patients throughout the hospital and the state.

Hormonal therapy offers a more reasoned approach to the cancer problem since here one knows that certain cancers in animals are clearly hormonally dependent and in man quite possibly so. The advances of hormonal control of most types of cancer of the prostate and some types of cancer of the breast are already apparent. There are strong indications that other tumors in man may be influenced or even controlled by the hormonal approach. Leukemia, with its tragic appearance in children as well as adults, young and old, has long been a challenge. A number of modifications of radiation therapy and chemotherapy have helped to control leukemia. None has cured it; none is really completely satisfactory. Progress in hematology will contribute significantly to understanding the problem of leukemia.

Since cancer is not a single disease but a great group of different diseases with essentially similar characteristics, it is doubtful that a single cure for all kinds of cancer will ever be found. Progress appears distressingly slow, as one eagerly awaits or strives for advances. In any new field hypotheses as to cause, as to cure, must be continually advanced, tested and either established or discarded. Proponents of one hypothesis or another may be enthusiastic. It is as necessary to guard against undue enthusiasm as undue apathy.

We see today a curious phenomenon. From many parts of the world comes evidence that there is an association between lung cancer and cigarette smoking. Lung cancer is rising at an alarming rate—a ninefold increase in reported deaths from 1930 to 1955. Some of this increase is due to improved diagnosis. Some of it must be real. In the face of this the percentage of cigarettes smoked rose last year. This does not necessarily imply neglect of the warning. It may imply faith in filters; it may imply a somewhat fatalistic attitude; it may imply that most people feel that the case against smoking has not been proved. I do not cite this example to advise you to stop or to continue smoking. I do not cite it to prove or disprove causative relationship between smoking and lung cancer. I do cite it to illustrate the great complexity of the cancer problem. Answers will not come quickly and easily. Answers are rarely complete when they come.

The improvement in the treatment of cancer has been great but it must be still greater. Complex as is the cancer problem, protean as are its manifestations, it is a problem that must be solved and that can be solved. The more potentials, such as the George Memorial, are added to the cancer problem, the greater will be the speed with which the final solution comes.



*Fuller*

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*Masters in Medicine . . .*INTRODUCTION TO ANATOMICAL EXERCISES  
ON THE GENERATION OF ANIMALS\*

BY WILLIAM HARVEY, DOCTOR OF PHYSIC,  
Professor of Anatomy and Surgery in the College of Physicians of London

*Introduction*

IT WILL NOT, I trust, be unwelcome to you, candid reader, if I yield to the wishes, I might even say the entreaties, of many, and in these Exercises on Animal Generation, lay before the student and lover of truth what I have observed on this subject from anatomical dissections, which turns out to be very different from anything that is delivered by authors, whether philosophers or physicians.

Physicians, following Galen, teach that from the semen of the male and female mingled in coition the offspring is produced, and resembles one or other, according to the *predominance* of this one or of that; and farther, that in virtue of the same predominance, it is either male or female. Sometimes they declare the semen masculinum as the *efficient cause*, and the semen femininum as supplying the *matter*; and sometimes, again, they advocate precisely the opposite doctrine. Aristotle, one of Nature's most diligent inquirers, however affirms the *principles* of generation to be the male and the female, she contributing the matter, he the form; and that immediately after the sexual act the vital principle and the first particle of the future foetus, viz. the heart, in animals that have red blood, are formed from the menstrual blood in the uterus.

But that these are erroneous and hasty conclusions is easily made to appear: like phantoms of darkness they suddenly vanish before the light of anatomical inquiry. Nor is any long refutation necessary where the truth can be seen with one's proper eyes; where the inquirer by simple inspection finds everything in conformity with reason; and where at the same time he is made to understand how unsafe, how base a thing it is to receive instruction from others' comments without examination of the objects themselves, the rather as the book of Nature lies so open and is so easy of consultation.

What I shall deliver in these my Exercises on Animal Generation I am anxious to make publicly

*\*Perhaps no better statement of the methods of science has yet been, or ever will be given than that of Harvey in the Introduction to his De Generatione. The compulsory study of this brief essay would alone justify the imposition, on every advanced student, of instruction in the history of medicine.*

F. D. Crookshank, M.D., F.R.C.P. in Cumston's *Introduction to the History of Medicine*.

known, not merely that posterity may there perceive the sure and obvious truth, but farther, and especially, that by exhibiting the method of investigation which I have followed, I may propose to the studious a new and, unless I mistake, a safer way to the attainment of knowledge.

For although it is a new and difficult road in studying nature, rather to question things themselves than, by turning over books, to discover the opinions of philosophers regarding them, still it must be acknowledged that it is the more open path to the secrets of natural philosophy, and that which is less likely to lead into error.

Nor is there any just cause wherefore the labour should deter any one, if he will but think that he himself only lives through the ceaseless working of his heart. Neither, indeed, would the way I propose be felt as so barren and lonely, but for the custom, or vice rather, of the age we live in, when men, inclined to idleness, prefer going wrong with the many, to becoming wise with the few through dint of toil and outlay of money. The ancient philosophers, whose industry even we admire, went a different way to work, and by their unwearied labour and variety of experiments, searching into the nature of things, have left us no doubtful light to guide us in our studies. In this way it is that almost everything we yet possess of note or credit in philosophy, has been transmitted to us through the industry of ancient Greece. But when we acquiesce in the discoveries of the ancients, and believe (which we are apt to do through indolence) that nothing farther remains to be known, we suffer the edge of our ingenuity to be taken off, and the lamp which they delivered to us to be extinguished. No one of a surety will allow that all truth was engrossed by the ancients, unless he be utterly ignorant (to pass by other arts for the present) of the many remarkable discoveries that have lately been made in anatomy, these having been principally achieved by individuals who, either intent upon some particular matter, fell upon the novelty by accident, or (and this is the more excellent way) who following the traces of nature with their own eyes, pursued her through devious but most assured ways till they reached her in the citadel of truth. And truly in such pursuits it is sweet not merely to toil, but even to grow weary, when the pains of discovering are

*continued on next page*

amply compensated by the pleasures of discovery. Eager for novelty, we are wont to travel far into unknown countries, that with our own eyes we may witness what we have heard reported as having been seen by others, where, however, we for the most part find

—minuit presentia famam:

that the presence lessens the repute. It were disgraceful, therefore, with this most spacious and admirable realm of nature before us, and where the reward ever exceeds the promise, did we take the reports of others upon trust, and go on coining crude problems out of these, and on them hanging knotty and captious and petty disputations. Nature is herself to be addressed; the paths she shows us are to be boldly trodden; for thus, and whilst we consult our proper senses, from inferior advancing to superior levels, shall we penetrate at length into the heart of her mystery.

### *Of the Manner and Order of acquiring Knowledge.*

Although there is but one road to science, that to wit, in which we proceed from things more known to things less known, from matters more manifest to matters more obscure; and universals are principally known to us, science springing by reasonings from universals to particulars; still the comprehension of universals by the understanding is based upon the perception of individual things by the senses. Both of Aristotle's propositions, therefore, are true: First, the one in his *Physics*,<sup>1</sup> where he says, "The way is naturally prepared, from those things that are more obvious and clear to us, to those things that are more obvious and clear by nature. For, indeed, the same things are not both known to us and extant simply: whence it is indispensable to proceed in this way, viz. from those things that are of a more obscure nature, but to us are more apparent, to those that are of a nature more obvious and distinct. Now those things are, in the first instance, more perspicuous and manifest to us that are most confused in fact; whence it is necessary to proceed from universals to particulars: for the whole, according to the dictates of sense, is the more obvious; and the universal is a certain whole." And again, that other in his *Analytics*,<sup>2</sup> where he thus expresses himself: "Singulars are to us more known, and are the first that exist according to the information of sense; for, indeed, there is nothing in the understanding which was not first in the sense. And although that reasoning is naturally prior and more known which proceeds by syllogism, still is that more perspicuous to us which is based on induction. And therefore do we more readily define singulars than universals, for there is more

of equivocation in universals: whence it is advisable from singulars to pass to universals."

All this agrees with what we have previously said, although at first blush it may seem contradictory; inasmuch as universals are first imbibed from particulars by the senses, and in so far are only known to us as an universal is a certain whole and indistinct thing, and a whole is known to us according to sense. For though in all knowledge we begin from sense, because, as the philosopher quoted has it, sensible particulars are better known to senses, still the sensation itself is an universal thing. For, if you observe rightly, although in the external sense the object perceived is singular, as, for example, the colour which we call yellow in the eye, still when this impression comes to be made an abstraction, and to be judged of and understood by the internal sensorium, it is an universal. Whence it happens that several persons abstract several species, and conceive different notions, from viewing the same object at the same time. This is conspicuous among poets and painters, who, although they contemplate one and the same object in the same place at the same moment, and with all other circumstances agreeing, nevertheless regard and describe it variously, and as each has conceived or formed an idea of it in his imagination. In the same way, the painter having a certain portrait to delineate, if he draw the outline a thousand times, he will still give a different face, and each not only differing from the other, but from the original countenance; with such slight variety, however, that looking at them singly, you shall conceive you have still the same portrait set before you, although, when set side by side, you perceive how different they are. Now the reason is this: that in vision, or the act of seeing itself, each particular is clear and distinct; but the moment the object is removed, as it is by merely shutting the eyes, when it becomes an abstraction in the fancy, or is only retained in the memory, it appears obscure and indistinct; neither is it any longer apprehended as a particular, but as a something that is common and universal. Seneca<sup>1</sup> explains this subtlety, according to Plato's views, in very elegant terms: "An idea," he says, "is an eternal copy of the things that have place in nature. I add an explanation of this definition, that the matter may be made plainer to you. I desire to take your portrait; I have you as the prototype of the picture, from which my mind takes a certain impression which it transfers to the canvass. The countenance, therefore, which teaches and directs me, and from which the imitation is sought, is the idea." A little farther on he proceeds: "I have but just made use of the image which a painter forms in his mind, by way of illustration. Now, if he would paint a likeness of Virgil, he forms an intuitive

<sup>1</sup>Lib. i, c. 2, 3.

<sup>2</sup>Post, 2.

<sup>1</sup>Epist. 58.



image of his subject; the idea is the face of Virgil, the type of his future work; and this which the artist conveys and transfers to his work is the resemblance or portrait. What difference is there? you ask: the one is the pattern or prototype, the other the form taken from the pattern and fixed in the work; the artist imitates the one, he creates the other. A statue has a certain expression of face; this is the Eidos, the species or representation; the prototype himself has a certain expression, which the statuary conceiving, transfers to his statue: this is the idea. Do you desire yet another illustration of the distinction? The Eidos is in the work; the idea without the work, and not only without the work, but it even existed before the work was begun." For the things that have formerly been noted, and that by use or wont have become firmly fixed in the mind of the artist, do, in fact, constitute art and the artistic faculty; art, indeed, is the reason of the work in the mind of the artist. On the same terms, therefore, as art is attained to, is all knowledge and science acquired: for as art is a habit with reference to things to be done, so is science a habit in respect of things to be known: as that proceeds from the imitation of types or forms, so this proceeds from the knowledge of natural things. Each has its origin in sense and experience, and it is impossible that there can rightly be either art or science without visible instance or example. In both, that which we perceive in sensible objects differs from the image itself which we retain in our imagination or memory. That is the type, idea, forma informans; this is the imitation, the Eidos, the abstract species. That is a thing natural, a real entity; this a representation or similitude, and a thing of the reason. That is occupied with the individual thing, and itself is single and particular; this is a certain universal and common thing. That in the artist and man of science is a sensible thing, clearer, more perfect; this a matter of reason and more obscure for things perceived by sense are more assured and manifest than matters inferred by reason, inasmuch as the latter proceed from and are illustrated by the former. Finally, sensible things are of themselves and antecedent; things of intellect, however, are consequent, and arise from the former, and, indeed, we can in no way attain to them without the help of the others. And hence it is, that without the due admonition of the senses, without frequent observation and reiterated experiment, our mind goes astray after phantoms and appearances. Diligent observation is therefore requisite in every science, and the senses are frequently to be appealed to. We are, I say, to strive after personal experience, not to rely on the experience of others; without which, indeed, no one can properly become a student of any branch of natural science, nor show himself a competent judge of

what I am about to say on the subject of generation; for without experience and skill in anatomy, he would not better understand me than could one born blind appreciate the nature and difference of colours, or one deaf from birth judge of sounds. I would, therefore, have you, gentle reader, to take nothing on trust from me concerning the generation of animals; I appeal to your own eyes as my witnesses and judge. For as all true science rests upon those principles which have their origin in the operation of the senses, particular care is to be taken that by repeated dissection the grounds of our present subject be fully established. If we do otherwise, we shall but come to empty and unstable opinions; solid and true science will escape us altogether: just as commonly happens to those who form their notions of distant countries and cities, or who pretend to get a knowledge of the parts of the human body, from drawings and engravings, which but too frequently present things under false and erroneous points of view. And so it is, that in the present age we have an abundance of writers and pretenders to knowledge, but very few who are really learned and philosophers.

Thus much have I thought good, gentle reader, to present to you, by way of preface, that understanding the nature of the assistance to which I have trusted, and the counsel by which I have been led in publishing these my observations and experiments; and that you yourself in passing over the same ground, may not merely be in a condition to judge between Aristotle and Galen, but, quitting subtleties and fanciful conjectures, embracing nature with your own eyes, that you may discover many things unknown to others, and of great importance.

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*Annual Meeting—May 12-13, 1959*

**Rhode Island Medical Society**

## REPORT ON THE ACTIONS OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION AT THE 12th CLINICAL MEETING

At Minneapolis, Minnesota, December 2-5, 1958

CHARLES J. ASHWORTH, M.D., *Delegate*

**M**EDICAL SERVICES at adjusted (reduced) rates for persons over sixty-five with reduced incomes and very modest resources was asked by the House of Delegates of the A.M.A. membership meeting at Minneapolis, December 2-5. This action was unquestionably the most important result of the recent 12th clinical meeting and is hailed as a progressive step toward the solution of the medico-economic problems that have arisen from a constantly increasing old-age population.

Rhode Island shares this national interest even to a greater degree than other areas, because of the origin of legislation in the recent session of congress by our representative Aimee J. Forand, designed to give at federal expense medical care to our over sixty-five citizens. This technique of adjustment in charges on the part of all doctors to the financial circumstances of this age group, will result in making available at reduced premium rates, a prepayment insurance plan that will insure comprehensive medical care when required.

The Board of Trustees of the A.M.A. after careful study, gave the recommendation complete endorsement together with Blue Shield and other similar insurance carriers, and at the same time exhorted the profession to implement the program by appropriate action at the state and county society level as well as at the national level. A similar program from hospital insurance plans to provide lowered hospital costs for the age group is also eagerly desired.

An unusually effective stimulus was given to this item of business by the address of Governor Orville L. Freeman of Minnesota, who spoke at the opening session of the House. In a general way he asked for "the help of the leaders of the medical profession in working out a program that will most adequately meet the needs of our older citizens for health care and services of the highest quality."

More specifically he said:

It is because of this great need that legislation has been proposed in Washington,—and, no doubt, will be proposed again,—to expand the federal social security program to include hospital and medical insurance benefits under Old Age and Survivors' Insurance. It was introduced

at the last session of Congress in the Forand Bill, which, I believe, you officially and vigorously opposed.

Now, you certainly have the *right* to oppose such legislation if you believe it would be harmful to your profession. You have the *duty* to oppose it if you believe it would be harmful to the public. But if you do oppose it you also have the responsibility of helping to work out an alternative program to meet the need that we all know exists and becomes more serious every day.

A solution is urgently needed. Our costs for medical care for the aging must compete with increasing demands for greater expenditures for education and for mental health, and for scores of other urgent demands.

Similarly, Doctor Gunnar Gunderson of La Crosse, Wisconsin, president of the A.M.A., called upon the profession to exert leadership and imagination in meeting these pressing problems of changing times. The full proposal submitted by the Council on Medical Service and endorsed by the Board of Trustees says:

"For persons over 65 years of age with reduced incomes and very modest resources, it is necessary immediately to develop further the voluntary health insurance or prepayment plans in a way that would be acceptable both to the recipients and the medical profession. The medical profession must continue to assert its leadership and responsibility for assuring adequate medical care for this group of our citizens.

"Therefore, the Council on Medical Service recommends to the House of Delegates the adoption of the following proposal: That the American Medical Association, the constituent and component medical societies, as well as physicians everywhere, expedite the development of an effective voluntary health insurance or prepayment program for the group over 65 with modest resources or low family income; that physicians agree to accept a level of compensation for medical services rendered to this group which will permit the development of such insurance and prepayment plans at a reduced premium rate."

In order to effect the immediate implementation

of such a program, the House directed that copies of the proposal be distributed to medical society approved plans, including Blue Shield and private insurance programs, requesting their co-operation.

The agenda also included action on the following more important subjects:

The long-awaited report of the Commission on Medical Care Plans, appointed at the 1954 Clinical Meeting in Miami, was discussed for two hours at a reference committee hearing, but the House decided to defer action until the June, 1959, meeting. In so doing, the delegates adopted this statement:

"We respectfully suggest to the constituent associations reviewing the report in the interim, that their attitude regarding the report will be clarified if they arrive at some decisions in regard to the following basic points:

"1. *Free Choice of Physician* — Acknowledging the importance of free choice of physician, is this concept to be considered a fundamental principle, incontrovertible, unalterable, and essential to good medical care without qualification?

"2. *Closed Panel Systems* — What is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician?

"These suggestions acknowledge that the policy of the American Medical Association to encourage and support the highest quality of medical care for all patients remains unchanged. They question, however, whether attitudes toward the free choice of physician and the closed panel system may be undergoing evolutionary change."

The House recommended that the Board of Trustees invite the constituent associations to forward their replies to these questions to the Executive Vice President 60 days in advance of the June, 1959, meeting.

Considerable discussion centered on a resolution which would have recognized that constituent medical associations have the right to establish the relationship of the medical profession to the osteopathic profession within their respective states. The House decided that the resolution in question did not offer the appropriate solution to the osteopathic problem, but requested the Judicial Council to review past pronouncements of the House on osteopathy and the status of the laws of the various states. The Council was asked to present its report and recommendations at the June, 1959, meeting. The House "noted with favor that the American Osteopathic Association has amended its objectives as stated in its constitution by deleting reference to the cultism of Andrew J. Still."

The House approved a statement by the Council on Medical Education and Hospitals supporting the development of additional facilities for basic medical education, and it urged the entire profession to

give that policy strong support in order to correct misinterpretations of the Association's viewpoint regarding the supply of physicians.

"American medicine fully recognizes the needs being brought about by the increasing population, social and economic trends, and the changing dimensions of medical knowledge and its application." Urging careful analysis of those needs, the statement says that existing medical schools should consider the possibility of increasing their enrollments and developing new facilities. It also declares that American medicine has the responsibility to encourage the creation of new four-year medical schools and two-year basic science programs.

*continued on next page*

## RHODE ISLAND HOSPITAL MEDICAL EDUCATION PROGRAMS

*February 2, 1959*

CHESTER W. HOWE, M.D.

Associate Professor of Surgery at Boston University School of Medicine. Was intern (1936-38) and resident physician (1938-39) at Rhode Island Hospital.

### *Surgical Infections*

7:30 P.M. Peters House Auditorium

*February 16, 17, 18, 1959*

CHESTER M. JONES, M.D.

Professor of Clinical Medicine at Harvard Medical School. Physician-in-Chief, *pro tem*.

*March 20, 1959*

CHARLES A. HUFNAGEL, M.D.

Professor of Surgery and Director of Experimental Surgical Laboratory at Georgetown University Medical Center.

### *Surgical Treatment of Cardiac Valvular Insufficiency*

7:30 P.M. Peters House Auditorium

*April 24, 1959*

HENRY L. JAFFE, M.D.

Director of Laboratories, Hospital for Joint Diseases, New York City.

### *Bone Tumors—The Correlation of the Clinical and Roentgenographic Findings with the Pathologic Findings*

7:30 P.M. Peters House Auditorium

*May 11 or 15, 1959*

(to be announced)

WILLIAM REGELSON, M.D.

Roswell Park Memorial Institute, Buffalo, New York.

### *Chemotherapy of Neuroplasms*

7:30 P.M. Peters House Auditorium



A Board of Trustees report on the administrative structure of the Association was approved by the House. The report informed the House that the Chicago staff has been divided into the following seven divisions: Business Division, Law Division, Communications Division, Field Division, Division of Scientific Publications, Division of Socio-Economic Activities and Division of Scientific Activities. The latter two are still in the process of development and are temporarily under the direction of the Assistant Executive Vice President. The Board also reported that the Committee on Legislation has been renamed the Council on Legislative Activities, with the Director of the Law Division as Council secretary. This new council will undertake an enlarged, strengthened legislative program, closely coordinated with the activities of the new field staff and the Washington Office. The latter also has been reorganized, with over-all direction coming from Chicago.

The House received and commended the report of the Committee to Study A.M.A. Objectives and Basic Programs, which it said may be a significant milepost in the Association's history. In approving one of the committee's recommendations, the House referred to the Council on Constitution and Bylaws the following suggested amendment of Article II of the Constitution: "The objectives of the Association are to promote the science and art of medicine and the betterment of public health and an understanding of the socio-economic conditions which will facilitate the attainment of these objectives."

The House also recommended that the Board of Trustees establish a mechanism which will assume the responsibility for promoting active liaison with each national medical society. "In the scientific fields," the House declared, "the role of the A.M.A. should be primarily that of leadership, but every endeavor should be made to bring about co-ordination of the special fields of scientific interest of the other national medical organizations." The delegates also approved a recommendation that the Board of Trustees give serious consideration to opening the publications of the Association to a free and open discussion of socio-economic problems applicable to medicine.

Once again considering fund raising problems which have arisen since development of the concept of united community effort, the House passed a resolution which pointed out that the action taken last June in San Francisco has been interpreted by some as disapproving the inclusion of voluntary health agencies in United Fund drives. It then stated that "the American Medical Association neither approves nor disapproves of the inclusion of voluntary health agencies in United Fund drives." The resolution also requested the Board

of Trustees to arrange a top-level conference with the voluntary health agencies, the United Funds and other parties interested in the raising of funds for health causes, with a view toward resolving misinterpretations and other difficulties in this area.

In dealing with a wide variety of other subjects, the House also:

Took notice of the recent restrictive changes in the *Medicare* program; expressed regret at the substitution of federal facilities for private care in the areas mentioned, and urged the Association to encourage the re-establishment of services under the free choice principle to accomplish the original intent of the act;

Recommended that the Social Security Act be amended by Congress to permit states to combine the present four *Public Assistance* medical programs into a single medical program, administered by a single agency and making available uniformity of services to all eligible Public Assistance recipients in the state;

Authorized the Council on Medical Service to sponsor at the earliest practicable date a *Congress on Prepaid Health Insurance*;

Approved a plan to develop "Buyers' Guides" which will be sent to physicians to help their patients analyze the merits of available health insurance programs;

Approved a bylaw amendment which will allow *dues exemptions* for interns and residents serving in training programs approved by the Council on Medical Education and Hospitals;

Called to the attention of all individuals or institutions responsible for *intern and resident* training that medical services provided to patients in hospitals are the responsibility of duly licensed physicians;

Encouraged the voluntary registration of the *paramedical personnel* who assist physicians, but opposed the extension of governmental licensure and governmental registration at this time;

Heartily approved and lauded the purpose, content and format of THE A.M.A. NEWS and recommended continuance of the publication under its present and established policies;

Agreed with the Committee on Medical Practices that *relative value studies* should be conducted by each constituent medical association but not on a national or regional basis by the A.M.A.;

Urged each constituent society to establish a committee on *rehabilitation* to carry out activities recommended by the Board of Trustees;

Called for continued activity at all levels to stimulate the development of effective *poliomyelitis inoculation programs*;

Suggested that the Association take immediate steps toward developing a plan whereby reserve

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# The RHODE ISLAND MEDICAL JOURNAL

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## HOSPITAL SEPSIS AND THE STAPHYLOCOCCUS

THE RESURGENCE of interest locally in the problem of antibiotic resistant organisms is a reflection of world-wide concern over the problem. Although only forty per cent of positive resistant cultures in hospital practice show staphylococcus (the other sixty per cent being gram negative bacilli), the resistant staphylococcus, by virtue of its peculiar toughness and its ability to produce serious and often tragic epidemic outbreaks, offers a challenge of considerable magnitude. Furthermore, aside from the possibility of discovering a definitive specific antibiotic, the problem of cross-infection and feed-back is essentially the same for both groups of organisms.

According to Paul Fremont-Smith of Boston, the emergence of resistant strains of staphylococcus represents survival of types with adaptable enzyme systems rather than the mutation of strains under the impact of exposure to antibiotic.

The important work on environmental sepsis by Doctor Carl W. Walter at Peter Bent Brigham Hospital, upon which he reported at a recent meeting of the Providence Medical Association, merits greater attention than it has received in the past. Wound infection, he emphasizes, is the least of the grief in affected hospitals. Among other serious causes of morbidity and death are pneumonitis, enteritis, pyelonephritis, furunculosis (particularly in hospital personnel, such as laundry workers and porters), mastitis (not only post-partum, but of the newborn), and parotitis, which a few years

ago had all but disappeared from hospital experience.

According to Doctor Walter the "four great multiplying cycles" are the nasopharynx, the floor, the laundry, and air-conditioners. His vivid descriptions of the sloppy cake soap, the wet mop, the messy laundry chute, the innocent appearing, but deadly bedside water carafe, and the slimy, neglected air-conditioner filter are hair-raising classics. So many time-honored hospital practices enter into the feed-back and multiplier mechanisms that it has thus far too often proved impractical to the point of frustration to break into the vicious cycle, human nature and habit patterns being what they are.

Although it is unlikely that the threat will ever be completely eradicated, considerable progress, nevertheless, should be possible. It seems to us that there are three main lines of attack:

1. Research, basic and clinical
2. Return to basic principles of aseptic technique
3. Hospital standardization

In the first category lies further investigation of the biology of the involved organisms and the search for newer and more effective antibiotics. In this connection a recent study by Captain George L. Calvy, USN, of St. Albans Naval Hospital is pertinent. In this study he reported on the successful treatment of forty cases of staphylococcus pneumonitis with ristocetin, a new and thus far potent antibiotic. For this work he was awarded the Edward

*concluded on next page*

Rhodes Stitt prize of the Association of Military Surgeons. There is, incidentally, a considerable sentiment among authorities in this field that antibiotics such as ristocetin should be kept in reserve, to be available for just such emergencies as Doctor Calvy was called upon to meet.

In the category of basic principles, one can mention such pedestrian matters as the rejuvenation of aseptic techniques and isolation on the medical and pediatric wards, frequent hand washing, the wearing of masks when affected by colds, the wearing of gloves for dirty dressings, avoidance of breaks in techniques in the operating room, good operating room decorum, gentle handling of tissues, and the avoidance of unnecessary exposure of tissue to contaminated air by slow-motion surgery.

Perhaps the greatest opportunity for progress lies in the third category: hospital standardization. It is possible, for example, according to Doctor A. N. Solberg, an engineer at the University of Toledo, Ohio, who has been studying the matter for seven years, to remove 97% of microorganisms from the air by appropriate air-conditioning apparatus and good maintenance. It is encouraging to learn, therefore, that the Joint Commission on Accreditation of Hospitals has become actively concerned with the problem. By the use of its policing powers, if applied with a realistic sense of the attainable, it should be possible to break into the vicious cycle of ingrained hospital procedure. By this new approach it should now be feasible to standardize on sound sanitary principles such diverse hospital operations as the laundry, housekeeping and the engineering department. We wish the Joint Commission every success in this important undertaking and urge upon the hospitals of our state their conscientious co-operation.

#### THE 11th ISAAC GERBER ORATION

Printed elsewhere in this issue of the Journal is the Eleventh Annual Doctor Isaac Gerber Oration, sponsored by the Medical Staff Association of the Miriam Hospital, and delivered by Doctor Leo M. Davidoff of New York City. These lectures have become a fixed tradition upon the local scene and the present essay maintains the usual high standard of cultural and scientific excellence. To recapitulate the contents of this thoughtful paper would be but "to gild refined gold." It would be more appropriate to urge our readers to peruse its contents carefully. It may not be amiss, however, to call attention to its major proposition that the skull, as the covering of the brain, conforms to its contour and not the brain to a rigid skull. In this, nature has long anticipated a thesis of modern architecture that form should reflect function.

#### RHODE ISLAND'S PLACE IN THE STUDY OF CANCER

In his address at the laying of the cornerstone of the George Building at Rhode Island Hospital, Doctor Shields Warren, distinguished pathologist and Charles V. Chapin orator, summarizes the present status of the world-wide effort to solve this most pressing of health problems and indicates the part that can be played by the activities centered in this building. He makes it clear that patients in this new unit, who are receiving the excellent care that is characteristic of the Rhode Island Hospital, can also be the objects of studies which, while of benefit to them as individuals, can contribute to an understanding of the terrible affliction from which each of them suffers. As Doctor Warren points out, it is well-planned research that has resulted in the mass of information about neoplastic disease which has been accumulated, and it is a continuation of such research, the exploration of every possible road and alley (many of which must, of course, be proved to be "blind") before the goal is reached. Close association with the research activities at Brown University and other institutions will be of the greatest value, and the combined effort will produce results.

But what, one may ask, can we expect of our activities here in Rhode Island in the solution of a problem which has thus far defied the efforts of the best staffed agencies and most competent investigators of the whole world? We must remember that progress is being made and many, many pertinent facts are being accumulated. These facts are available to all. Careful study can show where we stand in our knowledge of every facet of this complicated problem. The person who is needed is the investigator with imagination who can, so to speak, put two and two together—or, in other words, correlate these known facts, develop a new hypothesis and work it out to a solution. Somewhere there may well be another Banting or another Minot who, building on what is known, will point the way to the solution. He, or she, may even be here in Rhode Island!

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## DISTRICT MEDICAL SOCIETY MEETINGS

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### PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, November 3, 1958. The meeting was called to order at 8:30 P.M. by Doctor Joseph G. McWilliams, president.

The minutes of the previous meeting were not read. The president reported that the minutes of the meeting were to be published in the RHODE ISLAND MEDICAL JOURNAL.

Doctor Michael DiMaio read an invitation to the members of the Association to attend the Second Murray S. Danforth Oration, to be delivered at the Peters House, Rhode Island Hospital, on Thursday, November 6.

Doctor McWilliams presented membership certificates to the physicians elected to active membership in the Association at the October meeting.

Doctor McWilliams announced that the committee of Doctors Henry Weyler and Alex M. Burgess, Sr., had prepared the Association's tribute to the late Doctor Henry J. Gallagher, who died in Akron, Ohio, earlier this year.

### *Scientific Program*

Doctor McWilliams introduced Doctor Harold W. Schnaper, of Washington, D. C. Doctor Schnaper is assistant professor of medicine, Georgetown University; assistant chief of medicine, and assistant director of professional services for research and education, Mt. Alto Veterans' Administration Hospital; attending physician, Georgetown and District of Columbia General hospitals. Doctor Schnaper addressed the Association on the subject of *Hypertension*.

He reviewed the history of the medical treatment of hypertension over the years.

The integrity of the blood vessels depends upon the elevation in blood pressure, especially the diastolic blood pressure.

The Rauwolfia preparations are useful primarily in neurogenic hypertension. In combination with other drugs, Rauwolfia preparations are effective in 30% of the patients. The speaker pointed out, however, that the drug is depressing and has resulted in suicide in at least five cases to his knowledge.

In 1955, Chlorothiazide was prepared and in the speaker's opinion, is the most significant recent advance in the treatment of high blood pressure. It was originally used as a diuretic but it wasn't long after that its anti-hypertensive properties were discovered.

Diuril may be used in conjunction with Hydralazine and or with ganglionic blocking agents to increase its anti-hypertensive properties since, by itself, it is a mild anti-hypertensive agent. The speaker feels that the combined use of Diuril and Hydralazine is the best combination. Rauwolfia may be added if necessary. In other words, Diuril potentiates and increases the effect of other anti-hypertensive agents.

Diuril is helpful in toxemia of pregnancy.

The speaker also mentioned in passing, the toxic effects of the agents mentioned. Hypopotassemia, hypochloremia and hyponatremia are the most common side effects.

### *Adjournment*

The meeting was adjourned at 9:40 P.M.

Attendance was 94.

Collation was served.

Respectfully submitted,

MICHAEL DIMAIO, M.D., *Secretary*

\* \* \*

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, December 1, 1958. The meeting was called to order at 8:30 P.M. by Doctor Joseph G. McWilliams, president.

The minutes of the previous meeting were not read, and the president reported that they would be published in the RHODE ISLAND MEDICAL JOURNAL.

### *Report of the Secretary*

Doctor Michael DiMaio reported that at a recent meeting the Executive Committee had taken the following action:

It approved of the transfer of membership to the Woonsocket District Medical Society for Doctor Oscar Stapans.

It reviewed a report from the Interprofessional Committee of the State Pharmaceutical Association

*concluded on page 37*

## PROVIDENCE MEDICAL ASSOCIATION

*concluded from page 36*

and the Medical-Pharmaceutical Committee of the Rhode Island Medical Society, and requested further data on proposals for an educational program relative to mutual problems between the two groups.

In accordance with the bylaws it prepared and submitted in writing a slate of nominees as Officers for the Association for 1959. This slate was listed on the announcement of the December first meeting of the Association which was sent to every member. Counter nominations may be made in accordance with the rules set forth on the announcement card.

*Applicants for Membership*

The secretary reported that the Executive Committee had received and reviewed applications filed for active membership in the Association, and that it recommended the election of the following physicians: Juan A. Alonso, M.D.; Walter C. Cotter, M.D.; Alfred L. Quartaroli, M.D.; Yo Seup Song, M.D.

*Action:* It was moved that the nominees be elected to active membership. The motion was seconded and adopted.

*Scientific Program*

Doctor McWilliams presided at a panel discussion on the subject of *Staphylococcal Infections*. The discussors were Paul Fremont-Smith, M.D., director, Bacteriology and Infectious Disease, Peter Bent Brigham Hospital, Boston, Massachusetts; and Carl Walter, M.D., senior surgeon, Peter Bent Brigham Hospital, Boston, Massachusetts.

The very important problem of staphylococcal infections was covered in a very interesting manner by the speakers. A spirited question-answer session followed the formal presentation of the papers.

It is hoped that the details of the entire meeting will be published in a subsequent issue of the Journal.

*Adjournment*

The meeting was adjourned at 10:40 P.M.

Attendance was 88.

Collation was served.

Respectfully submitted,

MICHAEL DiMAIO, M.D., *Secretary*

## WOONSOCKET DISTRICT MEDICAL SOCIETY

The annual meeting of the Woonsocket District Medical Society was held at 8:30 P.M., in the Woonsocket Hospital cafeteria on December 9, 1958. President Charles E. Brochu presided.

The first order of business, after acceptance of the reading of the record of the prior meeting, was a vote on a proposed change in the Society's by-

laws whereby the Society's delegates and councilors to the Rhode Island Medical Society would serve for terms of five years. The amendment was passed and now becomes effective.

Doctor Saul A. Wittes reported that the House of Delegates had considered Medicare problems and Physician Service problems, but that no definite conclusions had been reached.

The application of Doctor Oscar E. Stapan for membership in our Society was read, along with a letter from the Providence Medical Association which stated that it approved his transfer. He was accepted.

Dr. Thomas J. Lalor and Dr. Phillip Morrison discussed problems relating to the payments for indemnities under the special coverages offered by Blue Cross and Physicians Service. A motion was made and passed that a communication presenting the problem be directed to the House of Delegates of the Society with the request that it take up the question involved with Physicians Service.

Dr. Saul A. Wittes discussed the question of social security coverage for physicians, and he agreed to report further on the subject at the next meeting of the Society.

The question of physicians serving on the Board of Trustees of a hospital was brought up by Dr. Thomas Lalor. After discussion of the matter, it was agreed that the Secretary should communicate with the American Medical Association to seek its ruling on such participation by physicians.

President Brochu appointed a Nominating Committee consisting of Doctors Cyril Israel, Ernest L. Dupre, and Philip J. Morrison who returned the following slate of officers which was duly elected for the coming year.

*President* ..... EDWARD B. MEDOFF, M.D.

*Vice-President* ..... VICTOR H. MONTI, M.D.

*Secretary* ..... ALTON P. THOMAS, M.D.

*Treasurer* ..... PAUL E. BOUCHER, M.D.

*Councilor* ..... RICHARD H. DOWLING, M.D.

(To serve until December, 1962)

*Delegates* ..... SAUL A. WITTES, M.D.

JOSEPH A. BLISS, M.D.

*Censors* ..... FRANCIS J. KING, M.D.

VICTOR H. MONTI, M.D.

AUREY FONTAINE, M.D.

The meeting adjourned at 10:30 P.M.

Refreshments were served.

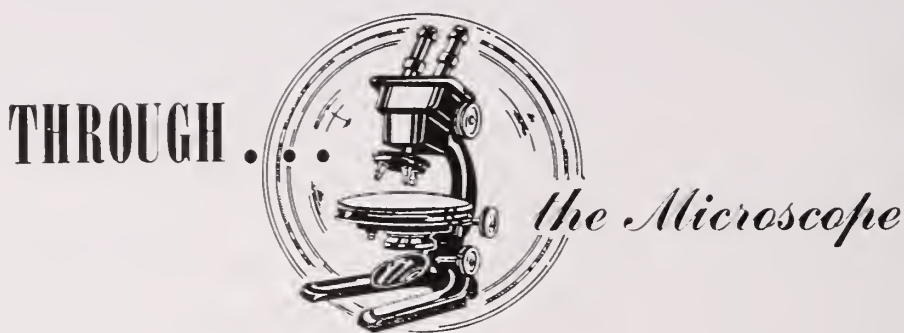
ALTON P. THOMAS, M.D., *Secretary*

*Cancer Conference for Physicians*

at the Medical Library

*Wednesday, March 18, at 2:00 P.M.*





### *Supply of Future M.D.'s Increases*

American medical colleges had a record enrollment of 29,473 students in 1957-58.

Sixty of the 85 operating medical schools reported major construction, costing 47 million dollars, in the planning, beginning, or completion stages.

Forty-nine schools reported major developments and changes in administrative organization, methods of student selection, curriculum, and financing.

An estimated 275 million dollars was spent by the medical schools in 1957-58, an increase of 13 per cent over the preceding year.

These were among the many facts and figures in the 58th annual report on medical education by the American Medical Association's Council on Medical Education and Hospitals.

There are 78 approved four-year medical schools in the United States, along with four two-year schools of basic medical sciences. In addition, three newly developing schools have provisional approval by the A.M.A. council and will be graduating students within the next few years. Ten years ago there were 77 schools, including seven two-year schools of basic medical sciences.

A total of 6,861 physicians was graduated from the 78 schools in 1958, as compared with 6,796 in 1957. The record year for graduates was 1955 with 6,977.

A new record was established in 1957-58 for the number of entering freshmen—8,030. The preceding year the number was 8,014 and 10 years ago the number was 6,487.

The median annual cost of medical school to a student, including tuition, minimum board, room, and supplies, in a private institution was \$1,958. In a state-owned school, the cost was \$1,395 to a resident of the state and \$1,731 to a nonresident.

The median amount of money spent by a four-year school during 1957-58 was between 2.3 and 2.4 million dollars.

### *National Foundation Offers Expanded Scholastic Program*

The National Foundation will offer annual Health Scholarships to help provide four years of college or university education in career preparation for five of the key professions: medicine, medical social work, nursing, physical therapy and occupational therapy.

A minimum of 505 Health Scholarships will be offered each year, the first of them before the end of the 1959 school year. They will be made available on a geographic basis with heavily populated states receiving as many as 25.

Rhode Island will receive five of these scholarships, one in each of the health professions indicated above.

The National Foundation's chapters, numbering more than 3,100, will have an active part in the program. They will seek and accept Health Scholarship applications, pass them on to state or territorial professional committees for selection, and will present awards to winners.

Because education requirements of the five professions vary, scholarships will be made available in

*Nursing, physical therapy and occupational therapy*, to all graduating high school students who have been accepted for an approved program by accredited colleges or universities;

*Medical social work*, at the college junior year, extending through two years of required graduate work; and in

*Medicine*, at the college junior, senior or first graduate year, depending upon the requirements of the medical school.

Winners of scholarships are not committed to work in health fields of special interest to the National Foundation, such as polio, arthritis or birth defects. Scholarship recipients are, however, expected to serve the health field at large, working in areas for which they are prepared.

### Maternal Mortality Rate Drops 93% in 40 Years

In its statistical bulletin, PROGRESS IN HEALTH SERVICES, the Health Information Foundation points out that the maternal mortality rate in this country has dropped 93 per cent in the last four decades—from 61 deaths per 10,000 live births in 1915 to 4.3 deaths in 1957.

One maternal death occurs in approximately 2,300 live births today, compared with one maternal death for each 165 live births in 1915. Last year, the Foundation stated, 4,200,000 babies were born in the United States; there were 1,600 maternal deaths. Had the rate of one generation ago still prevailed, the number of maternal deaths would have run as high as 28,000.

In actual fact, pregnancy and childbirth have become very minor causes of death in this country, accounting for only one tenth of 1 per cent of all deaths and only 4 per cent of all deaths among women of childbearing age. Accidents alone cause three times the number of deaths among women of reproductive age as maternity does.

Although maternal death rates have dropped among women of all the childbearing age groups, the greatest gains have been made by women at the younger ages. The safest age group is the 20-24-year-old; only 3.2 maternal deaths per 10,000 live births occur in this group. Next come women under 20 and those in the 25-29 group, each with a rate of 4.3.

Much of the improvement in childbirth safety, says H.I.F., "is attributable to the high level of pre-natal care and hospitalization for birth now customary in this country." In 1955, 94 per cent of all live births occurred in hospitals, and 97 per cent of all births came with a physician in attendance.

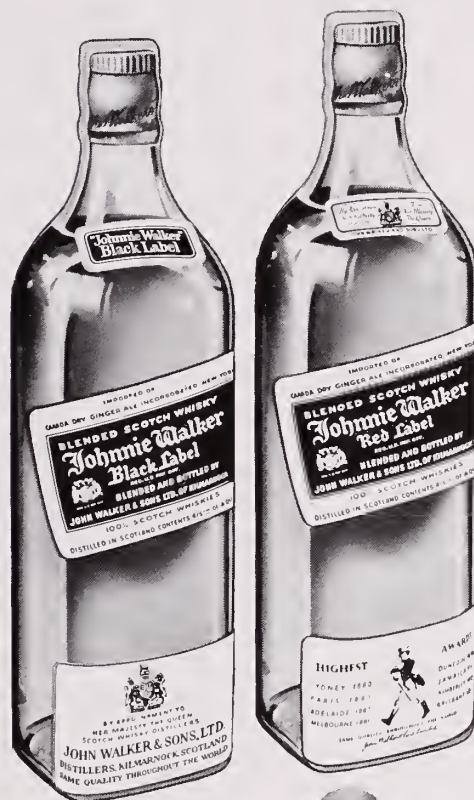
### Inpatient Care Institutions to be Listed

The board of trustees of the American Hospital Association has voted to list inpatient care institutions other than hospitals in the same manner as the Association's listing for approved hospitals. The listing program, Doctor Edwin L. Crosby, director of the Association, states, has as its primary purpose the provision of a census of hospitals, not a measure of quality of care. Listing requirements for institutions other than hospitals include the following:

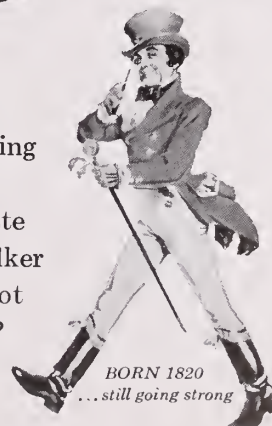
1. The provision of beds for the care of patients.
2. State licensure and compliance with local governmental regulations.
3. A licensed physician or physicians to "advise on medical administrative problems, review the institution's plan for patient care, and handle emergencies if the patient's physician is unavailable."
4. "Each patient shall be under the care of a duly

*continued on next page*

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skill in the art  
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are reflected  
in the good taste  
of Johnnie Walker  
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try some soon?



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**SCOTCH WHISKY**

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licensed physician, and shall be seen by a physician as the need indicates."

Other requirements included the maintenance of medical records for each patient, arrangements to provide diagnostic services, the supervision of the nursing service by a registered nurse or a licensed practical nurse with a registered nurse serving as a consultant, and the serving of food which meets the patient's "nutritional and dietary requirements."

### *Paralytic Polio is Yet to be Conquered*

The incidence of polio has dropped a dramatic 85 per cent in the three-year period ending last year, but paralytic polio, the ailment's most withering form, is increasing among preschool children.

This changing trend in the polio picture is disclosed in the recent issue of *PATTERNS OF DISEASE*, prepared by Parke, Davis & Company for the medical profession.

Since 1955, the number of polio cases has dropped for three consecutive years, from 28,985 cases in 1955 when the vaccination program was begun to 5,485 in 1957. Years of low polio incidence usually follow high ones, "Patterns" notes, and the only previous period during which incidence declined for three consecutive years was 1917 to 1919.

However, children under 5 "have been accounting for an increasing share of paralytic cases since 1955," the publication reveals. It points out that two thirds of polio cases, both paralytic and non-paralytic, occur in children under 15.

In 1955, children in the under 5 age group accounted for 32 per cent of paralytic polio cases as compared to 33 per cent for children in the 5 to 15 age group. In 1957, this ratio changed substantially—45 per cent as compared to 26 per cent.

"This shift has been attributed to more widespread vaccination of children of school age," "Patterns" says.

It discloses also a changing pattern in the incidence of paralytic and non-paralytic polio. Last year, the total reported cases of paralytic polio showed a sharper drop over the previous year than non-paralytic polio cases (73 per cent as against 57 per cent). "In 1958, this trend appears to be reversed," according to the publication. Between April 1st and August 2, 1958, for example, about 48 per cent of polio cases were reported to be paralytic as compared with 31 per cent during the same period in 1957.

### *Twenty Days Per Person Per Year*

Illness or injury caused the American people to stay home from work, stay in bed, or otherwise cut down on normal activities for about 3 billion 400 million days during the year ending June 30, 1958.

This total of disability, which averaged 20 days

per person per year, is reported in the first U. S. National Health Survey publication to provide figures from a full year of nationwide household interviewing.

The report gives selected statistics on acute conditions, chronic conditions, persons injured in accidents, physician visits, dental visits, and disability.

Acute illnesses, including acute respiratory conditions, totaled 437,900,000, or an average of about 2.6 per person. How many of these illnesses were caused by Asian influenza is not known. However, the report shows that acute respiratory conditions caused an average of about seven days of restricted activity per person, including days in bed or days lost from work or school.

About 47,000,000 persons were injured seriously enough during the year to cause them to restrict their activities for a day or more or seek medical attention, the report shows. Injuries caused 424,100,000 days of restricted activity, or 2.5 days per person.

The importance of chronic conditions is indicated by the fact that circulatory diseases alone were the cause of 484,200,000 days of restricted activity, which would be the equivalent of about 2.9 days per person. The circulatory diseases rank higher than any other group of chronic conditions in this respect.

People visited their physicians 889,900,000 times, or an average of 5.3 times per person. People also went to their dentists 269,200,000 times, or 1.6 times per person on the average.

For most of the topics covered, the figures are shown by calendar quarter, pointing up the seasonal differences. Age, sex, and rural-urban residence are also shown in most instances.

The publication, *SELECTED SURVEY TOPICS, UNITED STATES, JULY 1957-JUNE 1958*, is Public Health Service Publication No. 584-B5. Copies are for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at 40 cents a copy.

### *Guide Developed to Measure Sick Absence From Work*

Work absence due to illness may cost American industry as much as ten billion dollars a year.

No one knows, however, exactly how much time is lost by workers because there is no uniformity in keeping records and defining absence.

A start toward solving the problems of uniform definitions and records has been made this year by the American Medical Association through its Committee on Medical Care of Industrial Workers.

The committee has just issued a preliminary guide for measuring work absence due to illness and injury. It contains various definitions and formulas which the committee hopes will serve as a

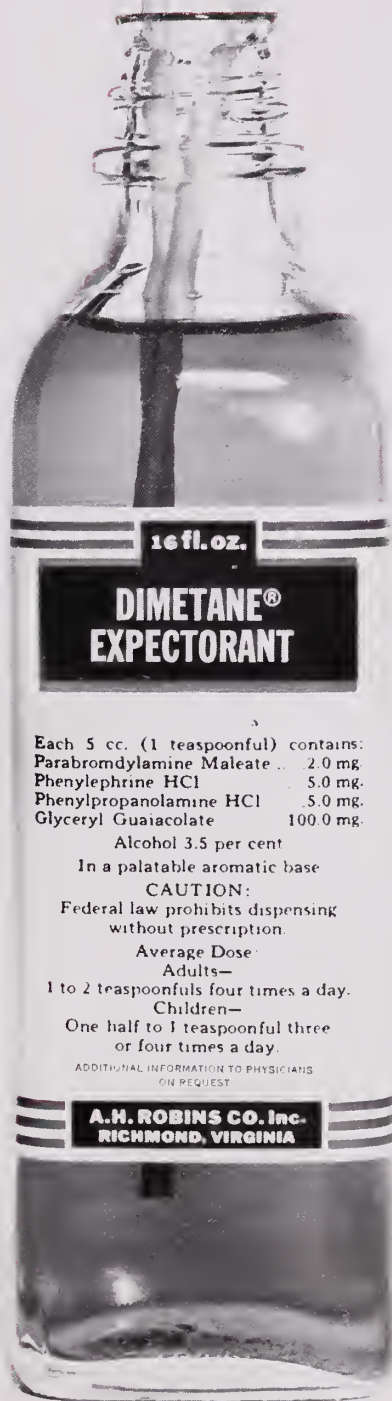
*continued on page 44*



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cough

tastes  
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the straws just symbolize the good flavor! And DIMETANE EXPECTORANT for cough is as effective as it is delicious. FORMULA: each 5 cc. (1 teaspoonful) contains: DIMETANE (Parabromdylamine Maleate) 2.0 mg.; Glyceril Guaiacolate 100.0 mg.; Phenylephrine Hydrochloride, USP 5.0 mg.; Phenylpropanolamine Hydrochloride, NNR 5.0 mg.; Alcohol 3.5% in a good-tasting aromatic base.



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combines the unsurpassed antihistamine Dimetane with the clinically proven expectorant glyceril guaiacolate (which increases R.T.F. almost 200%) and two recognized decongestants. When additional cough suppressant action is indicated, prescribe DIMETANE EXPECTORANT-DC, which provides the basic formula with dihydrocodeinone bitartrate 1.8 mg. per 5 cc. (exempt narcotic).

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Effective against more  
than 30 common pathogens,  
even including  
resistant staphylococci.

**Available forms:**

1. Panalba Capsules, bottles of 16 and 100 capsules. Each capsule contains:

Panmycin phosphate (tetracycline phosphate complex) equivalent to tetracycline hydrochloride .....250 mg.  
Albamycin (as novobiocin sodium)....125 mg.

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Panmycin (tetracycline) equivalent to tetracycline hydrochloride .....125 mg.  
Albamycin (as novobiocin calcium)...62.5 mg.  
Potassium metaphosphate .....100 mg.

**Dosage:**

Panalba Capsules. Usual adult dosage is 1 or 2 capsules 3 or 4 times a day.

**Panalba KM Granules**

For the treatment of moderately acute infections in infants and children, the recommended dosage is 1 teaspoonful per 15 to 20 lbs. of body weight per day, administered in 2 to 4 equal doses. Severe or prolonged infections require higher doses. Dosage for adults is 2 to 4 teaspoonfuls 3 or 4 times daily, depending on the type and severity of the infection.





## THROUGH THE MICROSCOPE

*continued from page 40*

foundation for the uniform collection of sickness absence statistics by management.

The guide is a preliminary one, which eventually will be revised on the basis of suggestions from companies and physicians using it.

According to the guide's foreword, the use of uniform definitions and measurements will insure comparability of sick absence records within a given industry from time to time, as well as between industries.

Its use, the guide foreword said, may help bring about "a clearer recognition of sick absence and a more accurate evaluation of its real impact upon industry and the employed population."

Among the guide's recommendations are:

—That a sick or injured employee absent from work be listed as on sick absence, not on "leave without pay" or "administrative leave," especially after the absence has exceeded a specified number of days.

—That sick absence be classified according to its origin—occupational or non-occupational.

—That duration of absence be based on calendar days rather than on work or "scheduled" days. This is in line with the practice used for sickness disability benefit payments and in sickness surveys among the general population.

—That medical terminology for recording diagnosis be based on THE STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS, a book which lists accepted terms for diseases and operations. Future revisions of the guide will contain a recommended nomenclature.

—That occupational categories be set up on a specific basis, with the major categories being managerial and supervisory; clerical and sales; skilled; and semi-skilled and unskilled.

The Committee on Medical Care for Industrial Workers is a joint committee of the A.M.A. Councils on Industrial Health and on Medical Service. Its chairman is Dr. Frank J. Holroyd, Princeton, W. Virginia. Copies of the eleven-page guide may be obtained from either of the A.M.A. councils.

*Use of Doctors Doubles in Thirty Years*

Americans now see physicians almost twice as often, on the average, as they did thirty years ago, Health Information Foundation reports.

The Foundation analyzed figures for out-of-hospital doctor visits from three separate surveys: one covering the 1928-31 period and two conducted within the last three years.

Three decades ago, the Foundation stated, Americans made an average of 2.6 visits a year to physicians. The current average is almost 5 visits a year.

Part of the increase can be explained by the fact that a higher proportion of people now see their doctor at least once a year. Less than half the population in 1928-31 saw a physician during the course of a year. Currently only about one person in three fails to do so. Even when only users of doctors' services are considered, the average number of visits per person has increased in the last thirty years.

Women tend to see physicians more often than men do, especially during the young-adult period, the Foundation said. By age, the lowest average use comes from 5 to 14. The highest usage is among persons 65 and over.

Today, the Foundation pointed out, "There is little difference in the volume of medical care received by people in widely separated income groups." In 1928-31, adults in high-income families averaged about half again as many visits as those with the lowest incomes. Currently the comparable advantage of high-income families is much less—only about one eighth.

Commenting on this trend, George Bugbee, Foundation President, said: "Clearly, medical care is generally available to the public regardless of ability to pay. This encouraging fact can be traced in part to today's relatively high income levels and to recent improvement in the medical services available to low-income groups. It also reflects the greater value now placed on medical care within the budget of the average family."

*Training Program in Psychiatry for GP's Offered*

The National Institute of Mental Health is offering grant support for a training program for general practitioners and other physicians engaged in the practice of medicine other than psychiatry. Funds are available during the current year (fiscal year 1959) for these grants and training institutions may submit applications at any time.


This program has two purposes:

1. To foster the development of postgraduate training in psychiatry for the practitioners who wish to increase their psychiatric knowledge and skills in order to be able to deal more effectively with the emotional aspects of illness generally and in order to play a more effective role in the treatment and prevention of mental illness. These courses will be designed for the physician who plans to continue practicing in his own field.

Grant support is being offered to medical schools, hospitals, clinics, and medical and psychiatric societies for the development and expansion of such postgraduate training in the form of courses, institutes, and seminars. This support does not include fees, subsistence, or travel for the physicians who attend.

Support of this type of training may be for a particular professional group over a given period.

*concluded on page 46*



it started  
as a  
"cold"...

to prevent  
the sequelae  
of u.r.i. ...  
and relieve the  
symptom complex

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Sinusitis, otitis, tonsillitis, adenitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.<sup>(1)</sup> To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN<sup>®</sup> Tetracycline HCl (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP, caffeine-free.

(1) Estimate based on epidemiologic study by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122, Jan. 1933.



LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



## THROUGH THE MICROSCOPE

*concluded from page 44*

or for training offered regularly as part of the post-graduate curriculum of a medical school, hospital, or clinic, or as part of the educational program of a medical or psychiatric society.

Physicians interested in obtaining this type of training should apply to medical schools, hospitals, clinics, and medical or psychiatric societies which have, or are developing, such training opportunities.

II. To provide support at an adequate level for psychiatric residency training for physicians in practice who wish to become psychiatrists. Training stipends up to a maximum of \$12,000 a year are available. The level of payment will be determined by the training institutions who will also make the award to the individual physicians. The National Institute of Mental Health will make awards of grants for this purpose to training institutions and not to individuals.

Physicians interested in support for this type of training should apply to training institutions which

## PRIVATE DUTY NURSES' FEES

The Private Duty Nurses' Section of the Rhode Island State Nurses' Association wishes to bring to your attention, that on December 1, 1958, the following salary schedules will go into effect for private duty nurses:

- |   |         |
|---|---------|
| 1. All general, medical and obstetrical service, per eight-hour day   | \$16.00 |
| 2. Communicable diseases in hospitals and homes, per eight-hour day   | 18.00   |
| 3. Alcoholic and mental patients in general hospitals and homes, per eight-hour day   | 18.00   |
| 4. Major cardiac and lung surgery, per eight-hour day   | 18.00   |
| 5. Twelve-hour duty in homes only   | 20.00   |
| 6. Twenty-hour duty in homes only   | 23.00   |
| 7. Multiple nursing (nursing of two patients on an emergency basis only, until another private duty nurse is available), per eight-hour day | 20.00   |
| 8. Chest surgery for two patients, per eight-hour day   | 24.00   |
| 9. Overtime is to be paid at the rate of time and one-half for time in excess of eight hours in any one day (in emergency only)             |         |
| 10. Hourly rates:   |         |
| a. First hour or fraction thereof (7:00 A.M.-7:00 P.M.)   | 2.75    |
| b. First hour or fraction thereof (7:00 P.M.-7:00 A.M.)   | 3.00    |
| c. Each successive hour thereafter  | 2.00    |

Starting on December 1, 1958, the private duty nurses of Rhode Island will adopt a new forty-hour pay schedule. Bills will now be rendered at the end of five days, instead of the seven-day schedule previously in effect. This new policy pertains only to the policy of rendering bills.

are approved for psychiatric residency training.

Inquiries about the program should be sent to DR. SEYMOUR D. VESTERMARK, *Chief, Training Branch, National Institute of Mental Health, National Institutes of Health, Bethesda 14, Maryland.*

*YOU - - at the office, the club,  
everywhere - - are judged to an  
important degree by your clothes.*

*Our garments go proudly any-  
where - - and 'belong'! They are  
made for you.*

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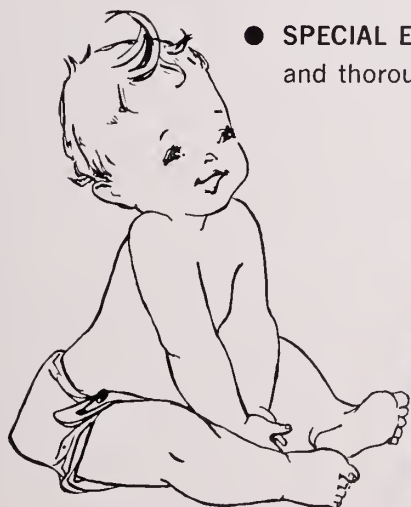
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- **VITAMINS A and E**... important to skin health and smoothness.
- **SPECIAL EMULSIFIERS**... to cleanse baby's skin gently, safely, and thoroughly — yet free from mineral oil.

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## BOOK REVIEWS

*DIAGNOSTIC MEDICAL PARASITOLOGY*  
by Edward Markell, Ph.D., M.D. and Marietta  
Voge, M.A., Ph.D. W. B. Saunders Co., Phila-  
delphia, Penna., 1958. \$7.00

This book, which is more a synopsis or handbook of medical parasitology than a textbook, is commended to those doing diagnostic laboratory work because it stresses distinctive features of the various human parasites which aid in rapid recognition without having to sift out unimportant detail and reference material that one can find in the textbooks on the subject. The book is well-suited to those doing parasitology in this country, for the parasites considered are those we find commonly or occasionally in this area.

Especially helpful is the chapter on *Pseudo-parasites and Pitfalls* for it is just as important to be able to recognize elements which resemble parasitic structures as to be able to recognize the actual structures of parasites, such as ova, cysts, trophozoites and other morphologic elements. There should be no confusion in this regard. The following chapter on *Special Diagnostic Methods* is also useful and covers several areas of diagnostic study of these organisms.

The book may be criticized in one area, but this shortcoming also applies to most books on the subject. There should be, in addition to the usual drawings or diagrams of the various life cycles of *Plasmodium* species, photomicrographs of these parasites as they actually appear in a blood preparation. Diagrams usually exaggerate the distinctive morphologic features.

However, the book is well-organized, well-written and contains very useful differential information about the various human parasites. It is recommended for everyday use in the clinical laboratory.

RAYMOND M. YOUNG, PH.D.

*TENTBOOK OF MEDICAL PHYSIOLOGY*  
by Arthur C. Guyton, M.D. W. B. Saunders  
Co., Phil., 1956. \$13.50

Physiology is taught the first year in medical school. What is taught depends on the professor and his ability to teach. The author of this text is a teacher who is given to his calling; and conse-

quently, we have an excellent teaching text. Pedagogy includes much: selection of subject material pertinent to the mainstream of medical progress and effective presentation. Arthur C. Guyton, M.D., professor and chairman of the department of physiology and biophysics, University of Mississippi School of Medicine, is a teacher in the best sense; he states in his preface that his book is the result of trial and error and experimentation in *teaching* physiology. The result in print bears out his efforts to produce a teaching text. The material covered is that usually covered in physiology. The improvement lies in the balanced sections without the usual over-devotion to the historical development of physiology and over-emphasis on neurophysiology and muscle physiology. There is clarity in the written word and simplicity and force in the frequent diagrams and illustrations. Visual aids are skillfully used as they must be for effective teaching.

Single authorship of a textbook is rarer today than formerly. Yet all our great textbooks have been the inspiration of a single teacher. Multiple authorship is inevitable in primarily designed reference works, but textbooks are not necessarily or even desirably so. The terrific burden placed on a single individual in covering a broad field is a task taken up by few but when well done, as is this *TEXTBOOK OF MEDICAL PHYSIOLOGY*, it is a satisfying work to behold.

ROBERT V. LEWIS, M.D.

*A DOCTOR SPEAKS HIS MIND* by Roger I.  
Lee, M.D. Little, Brown and Company, Boston,  
1958. \$3.00

This little volume is, as the author states in his introduction, *musings — mostly mundane but related to medical matters*. In it are discussed, in a rather haphazard way, various ideas on physicians — their proper purposes and behavior and their relation to the public and to each other. There is a great deal of wisdom in the book, such wisdom as comes to a physician who has spent his life in the study of medicine and its application to the care of the sick. The author, Dr. Roger I. Lee, is a distinguished physician who can base his ideas on years of experience in clinical, academic and military medicine, and the field of public health.

concluded on page 50



# running noses and open stuffed noses orally

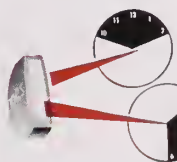
with TRIAMINIC, the oral nasal decongestant

- in nasal and paranasal congestion
- in sinusitis
- in postnasal drip
- in allergic reactions of the upper respiratory tract

safer and more effective than topical medication

- reaches *all* respiratory membranes systemically
- avoids "nose drop addiction"
- presents no problem of rebound congestion
- provides longer-lasting relief

Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours.



**first**—the outer layer dissolves within minutes to produce 3 to 4 hours of relief

**then**—the inner core disintegrates to give 3 to 4 more hours of relief

**Each TRIAMINIC Tablet provides:**

Phenylpropanolamine HCl . . . 50 mg.  
Pheniramine maleate . . . 25 mg.  
Pyrilamine maleate . . . 25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

**Dosage:** One tablet in the morning, mid-afternoon and in the evening, if needed.

# Triaminic®

**Also available:** For the occasional patient who requires only half dosage: timed-release TRIAMINIC JUVELETS. Each Juvelet is equivalent to  $\frac{1}{2}$  of a Triaminic Tablet.

For those patients who prefer liquid medication: TRIAMINIC SYRUP. Each 5 ml. tsp. of this palatable syrup is equivalent to  $\frac{1}{4}$  of a Triaminic Tablet.

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## BOOK REVIEWS

*concluded from page 48*

To a physician who, like the author, was brought up medically in Boston, the references to Dr. Shattuck, Dr. George Sears, Dr. Reginald Fitz and the others bring happy memories. The chapter on *Hero Worship* is pleasant reading to this reviewer who, as a medical student, not only came under the influence of these and other great physicians but learned to admire Dr. Lee as a young doctor of great ability and charm.

On most of the topics which Dr. Lee discusses the average experienced physician has formed ideas which are, I believe, similar to those expressed. The book will not add to their information nor clarify their thinking. On the other hand, it will be of some value to the lay public. Its statements are, for the most part, clearly and simply made, although in many chapters there is a considerable lack of coherence. It is quite as if the author were talking informally with a friend, and this very informality adds to its attractiveness. It is too bad the final chapter on *Medical Progress* was included, as it evidences a lack of understanding of some of the topics mentioned, and a few of the statements are incorrect. This is true of his discussion of cortisone. The reader would also get the impression that hemophilus influenzae is related to the disease influenza. Chiefly because of this chapter, one must hesitate to recommend the book.

ALEX M. BURGESS, SR., M.D.

*SURGERY IN WORLD WAR II—VASCULAR SURGERY.* Edited by Daniel C. Elkin, M.D. and Michael E. DeBakey, M.D. Medical Department, U.S. Army. Office of the Surgeon General, Wash., 1955. \$4.25

This volume is of little practical interest to the average physician but it is of great historical value to the entire medical world as it is, in fact, a detailed record of the observations made, and the methods developed, by a group of resourceful pioneers who, by the fortunes of war, found themselves responsible for organizing vascular surgical units during World War II.

It must be remembered that prior to that time, vascular surgery had made but little progress. The lack of established procedures in this field seemed at first to be a great handicap but later proved to be an advantage. It permitted these men to develop their own methods with minds uncluttered by precedent. The armed services produced a vast array of clinical material and the exigency of war provided the stimulus these men needed to proceed rapidly and boldly with the organization of vascular units. In spite of the urgency of their mission, this book reveals the care and thought they put into it. Every step is carefully recorded and every observation of

effect is listed in full. The analysis of results obtained is recorded without prejudice and may serve as an important reference as some of their work is "rediscovered" from time to time. Their greatest practical contribution to vascular surgery is, as would be expected, in the field of acute battle-incurred arterial injuries; however, their work was not at all confined to this but was extended to include all kinds of vascular diseases as would be found in such an enormous army.

The astounding development of this highly specialized branch of surgery during World War II is well known to most of us. We saw it in action during the war and immediately thereafter. We see it again now as the foundation upon which was built the truly remarkable vascular surgery of today.

This volume should be in every medical reference library and in the personal library of every surgeon interested in this particular field.

WALDO O. HOEY, M.D.

*CLINICAL HEART DISEASE* by Samuel A. Levine, M.D. Fifth edition. W. B. Saunders Co., Phil., 1958. \$9.50

The relatively thin, initial volume (1936) of Dr. Levine's familiar text has evolved over the years into the well-developed, but yet not adipose, current edition of nearly 700 pages. This reflects not verbosity but a necessary expansion to include the striking interim developments, especially in the fields of cardiopulmonary physiology, electrocardiography, direct measurements of cardiac functions, and the application of these findings to the surgical correction of congenital and acquired heart disease. The first part of the book is, as in previous editions, a series of essays, on various topics in cardiology, written in almost a conversational style, with a good deal of Dr. Levine's personal experiences as illustrations. The latter portion is devoted to clinical electrocardiography, which although rewritten by Dr. Harold D. Levine, still contains some material and tracings from the previous editions. This section retains the readable style and the clinical applications which make it excellent for the student, but it should not be regarded as a substitute for a standard text of electrocardiography for reference purposes.

Those who have the previous editions will certainly want the present one to bring their series up to date. Those others who have not previously spent some time—figuratively—with Dr. Levine may now acquire, in relatively easy fashion, much valuable information which the author has accumulated through years of extensive experience and astute observation.

IRVING A. BECK, M.D.

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### References:

1. Griebble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958.
2. Editorial: *New England J. Med.* 258:48-49, 1958.

**LEDERLE LABORATORIES**, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

\*Reg. U.S. Pat. Off.



## ON THE MEDICAL LIBRARY BOOKSHELVES

*Fifteen new titles have been added to the Davenport Collection and are available for circulation:*

Edith Bone—SEVEN YEARS SOLITARY. Harcourt, Brace & Co., N.Y., 1957.

H. H. Cunningham—DOCTORS IN GRAY. The Confederate Medical Service. Louisiana State University Press. Baton Rouge, 1958.

Terence East—THE STORY OF HEART DISEASE. The FitzPatrick Lectures for 1956 and 1957 given before the Royal College of Physicians of London. William Dawson & Sons, Ltd., Lond., 1957.

Martin Gardner—FADS AND FALLACIES IN THE NAME OF SCIENCE. Dover Publications, Inc., N.Y., 1957.

Margaret O. Hyde—MEDICINE IN ACTION. Today and Tomorrow. Whittlesey House, McGraw-Hill, N.Y., 1956.

Lester S. King—THE MEDICAL WORLD OF THE EIGHTEENTH CENTURY. University of Chicago Press, Chic., 1958.

George B. Mair—DOCTOR GOES EAST. Peter Owen Ltd., Lond., 1957.

Mary Louise Marshall—THE PHYSICIAN'S OWN LIBRARY. Its Development, Care and Use. Charles C Thomas, Springfield, Ill., 1957.

Achille Monti—ANTONIO SCARPA IN SCIENTIFIC HISTORY AND HIS ROLE IN THE FORTUNES OF THE UNIVERSITY OF PAVIA. Translation by Frank L. Loria. The Vigo Press, N.Y., 1957.

G. Canby Robinson—ADVENTURES IN MEDICAL EDUCATION. A Personal Narrative of the Great Advance of American Medicine. Published for the Commonwealth Fund by Harvard University Press, Cambridge, 1957.

Albert Schweitzer—INDIAN THOUGHT AND ITS DEVELOPMENT. The Beacon Press, Bost., 1956.

Frank G. Slaughter—SWORD AND SCALPEL. Doubleday & Co., Inc., Garden City, 1957.

Kenneth Walker—PATIENTS AND DOCTORS. The Layman's Guide to Doctoring. Penguin Books, Balt., 1957.

TO WORK IN THE VINEYARD OF SURGERY. The Reminiscences of J. Collins Warren (1842-1927). Edited, with Appendices, Notes and Comments, by Edward D. Churchill, M.D. Cambridge, 1958.

THE SELECTED LETTERS OF WILLIAM CARLOS WILLIAMS. Edited, with an Introduction by John C. Thirlwall. McDowell, Obolensky, N.Y., 1957.

### *Other purchases were:*

American Medical Association—AMERICAN MEDICAL DIRECTORY 1958. A Register of Physicians. . . Chic., 1958.

Paul B. Beeson & others, editors—THE YEAR BOOK OF MEDICINE (1958-1959 series). Year Book Publishers, Chic., 1958.

Randolph Lee Clark, Jr. & Russell W. Cumley, editors—THE YEAR BOOK OF CANCER (1957-1958 series). Year Book Publishers, Chic., 1958.

COLLECTED PAPERS OF THE MAYO CLINIC AND THE MAYO FOUNDATION, vol. 49, 1957. W. B. Saunders Co., Phil., 1958.

Edward L. Compere, editor—THE YEAR BOOK OF ORTHOPEDICS AND TRAUMATIC SURGERY (1957-1958 series). Year Book Publishers, Chic., 1958.

Council of State Governments—STATE ACTION IN THE FIELD OF AGING. 1956-57. A Progress Report. Chic., 1958.

William Dock & I. Snapper—ADVANCES IN INTERNAL MEDICINE. Vol. IX, 1958. Year Book Publishers, Chic., 1958.

Gilbert S. Gordan, editor—THE YEAR BOOK OF ENDOCRINOLOGY (1957-1958 series). Year Book Publishers, Chic., 1958.

T. R. Harrison & others, editors—PRINCIPLES OF INTERNAL MEDICINE. McGraw-Hill, N.Y., 1958.

E. P. Jordan, editor—THE PHYSICIAN AND GROUP PRACTICE. Year Book Publishers, Chic., 1958.

S. Z. Levine & others, editors—ADVANCES IN PEDIATRICS. Vol. X, 1958. Year Book Publishers, Chic., 1958.

William B. Wartman, editor—THE YEAR BOOK OF PATHOLOGY AND CLINICAL PATHOLOGY (1957-1958 series). Year Book Publishers, Chic., 1958.

Paul D. White & others—CARDIOVASCULAR REHABILITATION. McGraw-Hill, N.Y., 1957. Glanville Williams—THE SANCTITY OF LIFE AND THE CRIMINAL LAW. With a



Foreword by William C. Warren, Alfred A. Knopf, N.Y., 1957.

*Review volumes from the Rhode Island Medical Journal were:*

Curtis P. Artz & Eric Reiss—THE TREATMENT OF BURNS. W. B. Saunders Co., Phil., 1957.

Michael Bernreiter—ELECTROCARDIOGRAPHY. J. B. Lippincott Co., Phil., 1958.

H. V. Bronsted—THE ATOMIC AGE AND OUR BIOLOGICAL FUTURE. Philosophical Library, N.Y., 1957.

W. T. Catton—PHYSICAL METHODS IN PHYSIOLOGY. Philosophical Library, N.Y., 1957.

Ciba Foundation—COLLOQUIA ON ENDOCRINOLOGY. Vol. 12. Hormone Production in Endocrine Tumours. Edited by G. E. W. Wolstenholme & Maeve O'Connor. Little, Brown & Co., Bost., 1958.

Stanley Cobb—FOUNDATIONS OF NEUROPSYCHIATRY. 6th ed. Williams & Wilkins Co., 1958.

T. S. Danowski—DIABETES AS A WAY OF LIFE. Coward-McCann, Inc., N.Y., 1957.

H. A. F. Dudley & others—PRINCIPLES OF GENERAL SURGICAL MANAGEMENT. E. & S. Livingstone Ltd., Edin., 1958. Williams & Wilkins Co., Balt., exclusive U.S. Agents.

D. M. Dunlop & others, editors—TEXTBOOK OF MEDICAL TREATMENT. E. & S. Livingstone, Ltd., Edin., 1958. Williams & Wilkins Co., Balt., exclusive U.S. Agents.

Sir Howard Florey, editor—GENERAL PATHOLOGY. Based on Lectures Delivered at the Sir William Dunn School of Pathology, University of Oxford. 2nd ed. W. B. Saunders Co., Phil., 1958.

Charles K. Friedburg—DISEASES OF THE HEART. 2nd ed. W. B. Saunders Co., Phil., 1956.

Arthur C. Guyton—TEXTBOOK OF MEDICAL PHYSIOLOGY. W. B. Saunders Co., Phil., 1956.

HEALTHFUL SCHOOL LIVING. A Report of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association with the Cooperation of Contributors and Consultants. Edited by Charles C. Wilson. Wash., N.Y., 1957.

George A. Higgins & Thomas Orr, Jr.—ORR'S OPERATIONS OF GENERAL SURGERY. 3rd ed. W. B. Saunders Co., Phil., 1958.

Marc H. Hollender—THE PSYCHOLOGY OF MEDICAL PRACTICE. W. B. Saunders Co., Phil., 1958.

Roger I. Lee—A DOCTOR SPEAKS HIS MIND. Little, Brown & Co., Bost., 1958.

Edward K. Markell & Marietta Voge—DIAGNOSTIC MEDICAL PARASITOLOGY. W. B.

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Saunders Co., Phil., 1958.

Otis Marshall—MEMOIRS OF A G.P. Vantage Press, N.Y., 1958.

Medical Department, U.S. Army—SURGERY IN WORLD WAR II. Ophthalmology and Otolaryngology. Edited by Col. J. B. Coates, Jr. Office of the Surgeon General, Wash., 1957.

Medical Department, U.S. Army—SURGERY IN WORLD WAR II. Vascular Surgery. Edited by Daniel C. Elkin & Michael E. DeBakey. Office of the Surgeon General, Wash., 1955.

P. McG. Moffatt—AIDS TO OPHTHALMOLOGY. 11th ed. Bailliere, Tindall & Cox, Lond., 1957. Williams & Wilkins Co., Balt., exclusive U.S. Agents.

Richard W. Nice, editor—CRIME AND INSANITY. Philosophical Library, Inc., N.Y., 1958.

Dietrich C. Reitzes—NEGROES AND MEDICINE. Published for the Commonwealth Fund by Harvard University Press, Cambridge, 1958.

Berton Roueche—THE INCURABLE WOUND AND FURTHER NARRATIVES. Little, Brown & Co., Bost., 1958.

David D. Rutstein—LIFETIME HEALTH RECORD. Harvard University Press, Cambridge, 1958.

H. W. Scott-Wilson—AIDS TO BACTERIOLOGY. Bailliere, Tindall & Cox, Lond., 1957. Williams & Wilkins Co., Balt., exclusive U.S. Agents. Hermann Werner Siemens—GENERAL DIAGNOSIS AND THERAPY OF SKIN DISEASES. An Introduction to Dermatology for Students and Physicians. Translated from the German Edition by Kurt Wiener. University of Chicago Press, Chic., 1958.

S. J. Van Pelt—HYPNOTIC SUGGESTION. Its Role in Psychoneurotic and Psychosomatic Disorders. A Thesis. Philosophical Library, Inc., N.Y., 1956.

C. Stuart Welch & Samuel R. Powers, Jr.—THE ESSENCE OF SURGERY. W. B. Saunders Co., Phil., 1958.

*Fellows of the Society have given the following items:*

From *Irving A. Beck, M.D.*: "Greetings of the Season from Merrill Moore to Doctor Irving Beck 1956-1957" (pamphlet).

: 3 books and several periodicals.

From *Kenneth G. Burton, M.D.*: a collection of pamphlets from the Library of Dr. Murray S. Danforth.

From *John E. Douley, M.D.*: Harvey Cushing—A BIO-BIBLIOGRAPHY OF ANDREAS VESALIUS. Schuman's, N.Y., 1943.

: Geoffrey Keynes—A BIBLIOGRAPHY OF THE WRITINGS OF WILLIAM HARVEY, M.D. Discoverer of

the Circulation of the Blood. Cambridge, 1928.

: Andreas Vesalius—

THE EPITOME OF . . . Translated from the Latin with Preface and Introduction by L. R. Lind. The Macmillan Co., N.Y., 1949.

From *Charles L. Farrell, M.D.*: periodicals.

From *Seebert J. Goldowsky, M.D.*: TRANSACTIONS OF THE CONFERENCES ON SHOCK AND CIRCULATORY HOMEOSTASIS. Sponsored by the Josiah Macy, Jr. Foundation, N.Y. 1st-5th, 1951-1955.

From *Walter S. Jones, M.D.*: TRANSACTIONS OF THE NEW ENGLAND OBSTETRICAL AND GYNECOLOGICAL SOCIETY, vol. 9, 1955 & vol. 10, 1956.

From *Louis I. Kramer, M.D.*: periodicals.

From *F. Rouchese, M.D.*: Certificate of Membership of Gardner T. Swarts, M.D. in the International Anglo-Saxon Society, Sept. 6, 1911.

: ITALIAN-AMERICAN WHO'S WHO. A Biographical Dictionary of Italian-American Leaders. vol. XIV, 1955.

From the *Estate of Frank Mears Adams, M.D.*: 31 volumes.

From the *Estate of Lucius C. Kingman, M.D.*: TRANSACTIONS OF THE NEW ENGLAND SURGICAL SOCIETY, vol. 37, 1956 & vol. 38, 1957.

*Other gifts were:*

From the *Heirs of Ernest H. Brownell*: Certificate of Membership in the Rhode Island Medical Society of *Pardon Brownell, M.D.*

From *Abraham G. Kaufmann, M.D.*: periodicals.

From *Mr. C. M. Goethe*: subscription to EUGENICS QUARTERLY.

From *Kent County Memorial Hospital*: periodicals. Arthritis and Rheumatism Foundation—OSTEO-ARTHRITIS. A Handbook for Patients. N.Y., 1958. Gift of the Foundation.

Winfield Best & Frederick S. Jaffe—SIMPLE METHODS OF CONTRACEPTION. An Assessment of their Medical, Moral and Social Implications. N.Y., 1958. Gift of the Planned Parenthood Federation of America.

Chas. Pfizer & Co., Inc.—THE PASTEUR FERMENTATION CENTENNIAL 1857-1957. A Scientific Symposium. N.Y., 1958. Gift of the Pfizer Company.

Chicago Medical Society—CLINICAL CONFERENCE . . . March 5, 6, 7, 8, 1957. Gift of the Society.

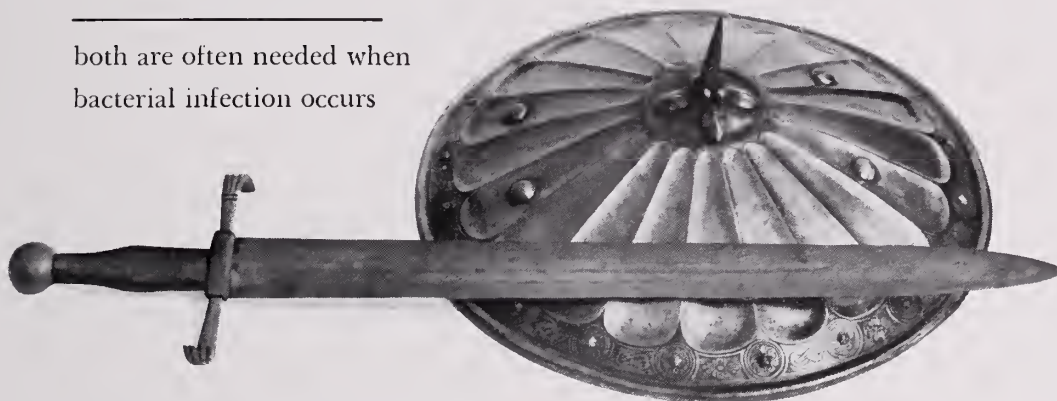
Ciba Foundation—COLLOQUIA ON AGEING. Vol. 4—Water and Electrolyte Metabolism in Relation to Age and Sex. Edited by G. E. W. Wolstenholme & Maeve O'Connor. Little, Brown & Co., Bost., 1958. Gift of the Foundation.

Ciba Foundation—SYMPOSIUM ON THE CEREBROSPINAL FLUID. Production, Circu-

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lation, and Absorption. Edited by G. E. W. Wolstenholme & Cecilia M. O'Connor. Little, Brown & Co., Bost., 1958. Gift of the Foundation.

Giba Foundation—SYMPOSIUM ON THE CHEMISTRY AND BIOLOGY OF MUCOPOLYSACCHARIDES. Edited by G. E. W. Wolstenholme & Maeve O'Connor. Little, Brown & Co., Bost., 1958. Gift of the Foundation.

Giba Foundation—SYMPOSIUM ON THE NEUROLOGICAL BASIS OF BEHAVIOR. Edited by G. E. W. Wolstenholme & Cecilia M. O'Connor. Little, Brown & Co., Bost., 1958. Gift of the Foundation.

COLLECTED REPRINTS OF THE GRANTEEES OF THE NATIONAL FOUNDATION FOR INFANTILE PARALYSIS, vol. XVIII, pts. 1 & 2, 1957. INDEX TO THE COLLECTED REPRINTS, 1952-1956. N.Y., 1958. Gift of the Foundation.

Connecticut State Dept. of Health—ONE HUNDRED AND SEVENTH REGISTRATION REPORT . . . Hartford (1957). Gift of the State of Connecticut.

Council on Drugs, A.M.A.—NEW AND NON-OFFICIAL DRUGS. Containing Descriptions of Therapeutic, Prophylactic and Diagnostic Agents . . . J. B. Lippincott Co., Phil., 1958. Gift of the American Medical Association.

DIRECTORY of Medical and Biological Research Institutes of the U.S.S.R. Gift of the U.S. Department of Health, Education, and Welfare.

Henry Dolger & Bernard Seeman—HOW TO LIVE WITH DIABETES. W. W. Norton & Co., Inc. N.Y., 1958. Gift of the Upjohn Company.

Wanda K. Farr & Althea Revere—EXAMINATION OF WHOLE CIGARETTE SMOKE BY LIGHT AND ELECTRON MICROSCOPY. N.Y., 1958. Gift of The Life Extension Foundation.

INDEX-CATALOGUE of Medical and Veterinary Zoology. Sup. 8. Gift of the U.S. Department of Agriculture.

Stanley Jablonski — RUSSIAN-ENGLISH MEDICAL DICTIONARY. Academic Press, Inc. N.Y., 1958. Gift of the Academic Press.

R. W. Lamont-Hayes, editor—SEROLOGICAL REACTIONS OF RHEUMATOID ARTHRITIS. N.Y., 1957. Gift of the Arthritis and Rheumatism Foundation.

Cesar E. Lopez — OBSTETRICIA SOCIAL. San Salvador, 1957. Gift of the Ministerio de Cultura.

Cesar E. Lopez—EL SERVICIO DE MATERNIDAD EN EL HOSPITAL ROSALES. San Salvador, 1955. Gift of the Ministerio de Cultura.

M. D. Anderson Hospital & Tumor Institute—

## RHODE ISLAND MEDICAL JOURNAL

VIRUSES AND TUMOR GROWTH . . . Houston, 1957. Gift of the University of Texas.

Horacio F. Marroquin—ENFERMEDADES DE LOS CONQUISTADORES. San Salvador, 1957. Gift of the Ministerio de Cultura.

Timothy Newell—THE FAMILY DOCTOR. A Cyclopaedia of Domestic Medicine and Hygiene . . . Bost., 1890. Gift of Miss Louise B. Smith.

PROCEEDINGS of the Ninth Annual Conference on the Nephrotic Syndrome. Edited by Jack Metcalf. N.Y., 1958. Gift of the National Nephrosis Foundation, Inc.

PROCEEDINGS of the Second National Cancer Conference 1952. 2 vols. Gift of the Rhode Island Cancer Society.

REPORT of the Henry Phipps Institute for the Study, Treatment and Prevention of Tuberculosis, 36th, 1956-57. Phil., 1958. Gift of the University of Pennsylvania.

REPORT of the Medical Research Council for the Year 1956-1957. Lond., 1958. Gift of the British Government.

Rockefeller Institute for Medical Research—STUDIES FROM . . . vol. 155, N. Y., 1958 and vol. 156, N.Y., 1958. Gift of the Institute.

SQUIBB CENTENNIAL MEDAL. Gift of E. R. Squibb & Sons.

Fredrick J. Stare & others—PROTEIN NUTRITION. Ann. N.Y. Acad. Sc. 69:855-1066, N.Y., 1958. Gift of the New York Academy of Sciences.

Robert M. Stecher — HEREDITY IN JOINT DISEASES. Basle, May 1957. Gift of the Arthritis and Rheumatism Foundation, Inc.

TRANSACTIONS of the American Clinical and Climatological Association the Seventieth Annual Meeting . . . vol. LXIX, 1958. Gift of the Association.

TRANSACTIONS of the Association of Life Insurance Medical Directors of America. Sixty-sixth Annual Meeting, vol. XLI, N.Y., 1958. Gift of the Association.

TRANSACTIONS of the Seventeenth Conference on the Chemotherapy of Tuberculosis, 1958 . . . Gift of the Veterans Administration-Armed Forces.

Wilmer Ophthalmological Institute — COLLECTED REPRINTS OF THE . . . Johns Hopkins Hospital, vol. XIII, 1955-57. Gift of the Institute.

*Received through exchange with the Universitetsbiblioteket, Lund, Sweden:*

Per-Ingvar Branemark—A METHOD FOR VITAL MICROSCOPY OF MAMMALIAN BONE MARROW IN SITU. Lund, 1958.

Per-H. Ekdahl — ON THE CONJUGATION AND FORMATION OF BILE ACIDS IN THE HUMAN LIVER. Lund, 1958.

Sven-Eric Lindell—EXPERIMENTS ON THE

*concluded on page 57*

## ON THE MEDICAL LIBRARY BOOKSHELVES

*concluded from page 56*

INACTIVATION OF HISTAMINE IN THE KIDNEY. Lund, 1958.

Nils Lundgren—STUDIES ON THE VASCULATURE OF THE CORPUS OF THE HUMAN UTERUS. Lund, 1957.

Göran Lundh—INTESTINAL DIGESTION AND ABSORPTION AFTER GASTRECTOMY. Stockholm, 1958.

Ake H. Thorson—STUDIES ON CARCINOID DISEASE. Lund, 1958.

Sten Widell—ON THE CEREBROSPINAL FLUID IN NORMAL CHILDREN AND IN PATIENTS WITH ACUTE A-BACTERIAL MENINGO-ENCEPHALITIS. Lund, 1958.

## BOOKS RECEIVED FOR REVIEW

The Editor acknowledges the receipt of the following books and thanks the publishers for sending them. Unfortunately, not every volume received is reviewed either because of lack of space or because the person to whom the book is assigned fails us. Whether reviewed or not, the books are appreciated and are available at the Library.

PHYSICAL METHODS IN PHYSIOLOGY by W. T. Catton, M.Sc. Philosophical Library, Inc., N.Y., 1957. \$10.00.

CIBA FOUNDATION COLLOQUIA ON ENDOCRINOLOGY. Vol. 11. HORMONES IN BLOOD. Edited by G. E. W. Wolstenholme & Elaine C. P. Millar. Little, Brown & Co., Bost., 1957. \$9.00.

CIBA FOUNDATION COLLOQUIA ON ENDOCRINOLOGY. Vol. 12. HORMONE PRODUCTION IN ENDOCRINE TUMOURS. Edited by G. E. W. Wolstenholme & Maeve O'Connor. Little, Brown & Co., Bost., 1958. \$9.00.

TEXTBOOK OF MEDICAL TREATMENT by various authors. Edited by D. M. Dunlop, M.D., Sir Stanley Davidson, M.D., & S. Alstead, M.D. 7th ed. E. & S. Livingstone, Ltd., Edin. & Lond., 1958. The Williams & Wilkins Co., Balt., exclusive U.S. agents.

A DICTIONARY OF DIETETICS by Rhoda Ellis. Philosophical Library, Inc., N.Y., 1956. \$6.00.

MODERN SEX LIFE by Edwin W. Hirsch, M.D. New American Library (Signet Books), N.Y., 1957. 35c.

MEMOIRS OF A G.P. by Otis Marshall, M.D. Vantage Press, N.Y., 1958. \$3.50.

THE RELIEF OF SYMPTOMS by Walter Modell, M.D. W. B. Saunders Co., Phil., 1955. \$8.00.

NEGROES AND MEDICINE by Dietrich C. Reitzes. Published for the Commonwealth Fund by Harvard University Press. Cambridge, 1958. \$7.00.

CARDIAC DIAGNOSIS—A Physiologic Approach by Robert F. Rushmer, M.D. W. B. Saunders Co., Phil., 1955. \$11.50.

LIFETIME HEALTH RECORD by David D. Rutstein, M.D. Harvard University Press, Cambridge, 1958. \$2.25.

AIDS TO BACTERIOLOGY by H. W. Scott-Wilson, B.Sc., B.M. Balliere, Tindall & Cox, Lond., 1958. 9th ed. \$3.50. Williams & Wilkins Co., Balt., exclusive U.S. agents.

Bickham-Callander SURGERY OF THE ALIMENTARY TRACT by Richard T. Shackelford, M.D. assisted by Hammond J. Dugan, M.D. 3 vols. W. B. Saunders Co., Phil., 1955. \$60.00.


THE STORY OF PEPTIC ULCER. Conceived by Richard D. Tonkin, M.D. Characterized by Raymond Keith Hellier, F.R.S.A. W. A. Saunders Co., Phil., 1957.

HYPNOTIC SUGGESTION. Its Role in Psychoneurotic and Psychosomatic Disorders by S. J. Van Pelt. Philosophical Library, Inc., N.Y., 1956. \$2.75.

THERAPEUTIC EXERCISE for Body Alignment and Function by Marian Williams, Ph.D. & Catherine Worthingham, Ph.D. W. B. Saunders Co., Phil., 1957. \$3.50.

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## RHODE ISLAND MEDICAL SOCIETY — NECROLOGY, 1958

*FREDERICK H. DEVERE, M.D.*, a practicing physician for more than fifty years, died on March 28, 1958, in Cranston.

Doctor Devere was born on November 6, 1876. He received his medical degree from the University of Vermont in 1898.

After practicing medicine for a while in Sterling, Massachusetts, he came to Cranston, Rhode Island, shortly before the First World War.

During World War II, he left semi-retirement and adopted a full schedule to help ease the doctor shortage. While he was never officially connected with government agencies, he took a vital interest in the Cranston School Department.

Doctor Devere was a member of the Providence Medical Association, the Rhode Island Medical Society, and the American Medical Association.

*HENRY J. GALLAGHER, M.D.*, a practicing physician in Providence for forty years, died in Akron, Ohio, on January 16, 1958. His death followed an illness that extended over a period of several years.

He was born in Providence, Rhode Island, on December 5, 1891. He attended Henry Barnard School, Classical High School, Brown University, and he was graduated from Tufts Medical School, *cum laude*, in 1917.

He was a World War I army veteran, having served as a medical captain in the Rhode Island unit of the A.E.F. He was a member of The Roger Williams Post, American Legion, No. 35, the Providence Medical Association, the Rhode Island Medical Society, and the American Medical Association.

At the time of his death he was consultant on the staff of the Rhode Island Hospital, having been a Visiting Physician for many years. He was also associated with Roger Williams, the Charles V. Chapin, and the Providence Lying-In hospitals.

*CHARLES H. GANNON, M.D.*, of Cranston, Rhode Island, died on March 1, 1958.

Doctor Gannon was born in Providence on July 30, 1886. He was graduated from the University of Maryland and the Maryland University School of Medicine.

He interned at St. Joseph's Hospital, then spent a year as a house physician at the Connecticut State

Prison. After another internship at St. John's Hospital, Lowell, Massachusetts, he joined the staff of the State Hospital for Mental Diseases at Howard. Until his recent illness he was a physician at the Adult Correctional Institutions at Howard. He had been associated with the state institutions in various capacities since 1931.

Doctor Gannon served in both World Wars. In 1918, he was commissioned as a first lieutenant in the Medical Corps. In World War II, he rose to the rank of lieutenant colonel and commanded the medical detachment of the 118th Combat Engineers of the Rhode Island National Guard.

He was a member of the Providence Medical Association, the Rhode Island Medical Society, and the American Medical Association.

*PRESCOTT T. HILL, M.D.*, a practicing physician for forty-five years in Providence, died at the Rhode Island Hospital on June 26, 1958, after a short illness.

He was born in Providence on August 10, 1885. He was graduated from Brown University with the Class of 1906, and the Harvard Medical School, Class of 1911.

Doctor Hill had been on the staff of Rhode Island Hospital from 1914 to 1947, and associate physician since that time. He also served on the staff of the Charles V. Chapin Hospital from 1916 to 1943 and more recently was consulting physician at St. Elizabeth's Home and the Bethany Home.

He was a fellow of the American Chest Physicians, the Rhode Island Medical Society, and the American Public Health Association. He was also a member of the American Trudeau Society and the American Academy of Tuberculosis Physicians.

*LUCIUS C. KINGMAN, M.D.*, a leading surgeon in Providence, and a past president of the Rhode Island Medical Society, died on June 19, 1958.

He was born in Providence on July 29, 1878, and he was graduated from Classical High School in 1896, from Yale University in 1900, and from Harvard Medical School in 1904. During the next two years he served a surgical internship at the Massachusetts General Hospital and an obstetrical internship at Boston Lying-In Hospital. His first appointment in Providence, in 1907, was to Rhode



Island Hospital. He remained a visiting surgeon there through 1938. He was a visiting surgeon at Chapin from 1928 to 1944.

At the time of his death, Doctor Kingman was a consultant at Rhode Island, Charles V. Chapin, Westerly, Pawtucket Memorial, Providence Lying-In and Veterans Administration hospitals. He was for many years a surgical consultant for Butler Hospital and the State Hospital for Mental Diseases. He had been chief of surgical service at Rhode Island Hospital from 1933 to 1939 and at Chapin from 1944 to 1946. From 1943 to 1947, Doctor Kingman was a member of the Providence Board of Hospital Commissioners, supervising the operation of Chapin Hospital.

Doctor Kingman served overseas with both the British Army and U.S. Navy during World War I. During World War II he served on a Rhode Island Medical Society committee that procured and assigned physicians for military and civilian needs. He also took an active part in Red Cross work during World War II, and was chief surgeon of the Civil Defense field forces here. He was a vice chairman of the Providence chapter of the Red Cross and a member of the home service committee.

Doctor Kingman was a member of the founders' group of the American Board of Surgery and belonged to the American College of Surgeons, the American Urological Association, and the American Medical Association. He was a past president of the Rhode Island Medical Society, the Providence Medical Association, and also the New England Surgical Society.

*WILLIAM H. MAGILL, M.D.*, a Providence medical examiner for forty-seven years, and for four years chief examiner for the state until his retirement in 1953, died on March 12, 1958, at the age of eighty-seven.

Doctor Magill was born in Providence on April 13, 1870. He was graduated from Brown University and Cornell Medical School.

He interned at Bellevue Hospital, New York City, from 1903 to 1905. He was on the surgeon's staff at Rhode Island Hospital from 1907 to 1948, and was an associate surgeon at St. Joseph's Hospital for many years. He was named the Providence Medical Examiner in 1906, holding that post until 1949 when he became the state's first examiner.

Doctor Magill was a member of the Rhode Island National Guard between 1907 and 1910. He also served on the Medical Draft Board during World War I.

He was a member of the Elks, Knights of Columbus, American College of Surgeons, Providence Medical Association, Rhode Island Medical Society, American Medical Association, and Cornell Medical Society.

*MARDEN H. PLATT, M.D.*, a practicing physician in Riverside for the past forty-six years, died suddenly on September 29, 1958.

Doctor Platt was born in Winooski, Vermont, on February 23, 1886. He was a graduate of the University of Vermont in the Class of 1910.

Doctor Platt was the oldest member of the staff at Pawtucket Memorial Hospital.

During World Wars I and II he served on the Selective Service Board of Providence County No. 2.

The doctor was a member of the Rhode Island Medical Society and the American Medical Association.

*HENRY B. POTTER, M.D.*, of Wakefield, who served as college physician for Rhode Island State College from 1905 until he retired in 1948, died at South County Hospital on September 15, 1958.

Doctor Potter was born in Cranston on February 9, 1876. He attended public schools in Cranston, the University of Michigan, and he received his medical degree from the University of Pennsylvania in 1899. After interning at Saint Joseph's Hospital and Rhode Island Hospital, he opened his own medical practice in South County in 1905.

Before the United States entered World War I, he went to France with the Harvard University Surgical Unit and became a captain in the Royal Army Medical Corps. He received a citation from the King of England for his work. He returned after the war to his duties at the state college, and also served as surgeon for the Coast Guard in the area.

He was a senior surgeon on the staff at South County Hospital, and was elected president of the hospital staff in 1938.

He was a member of the American Medical Association, the Rhode Island Medical Society, and the Washington County Medical Society.

*J. EDGAR TANGUAY, M.D.*, dean of Woonsocket physicians, died on January 5, 1958.

Born in St. Hyacinthe, Quebec, on August 12, 1876, he graduated from the Bishop College of Medicine, now McGill Medical School, in Montreal, in 1899.

Doctor Tanguay interned at Women's Hospital, Montreal, before coming to Woonsocket, where he practiced for fifty-eight years.

He retired as president of the Woonsocket Hospital Medical Staff in 1951 at which time he was elected permanent honorary president. In 1949, the Woonsocket District Medical Society honored Doctor Tanguay by presenting to him a plaque commemorating the fiftieth anniversary of his practice. Doctor Tanguay served as medical examiner in Woonsocket for a six-year period and assistant

*concluded on next page*

## REPORT ON A.M.A. MEETING

*concluded from page 32*

medical examiner for another six years. He was an examining physician for the School Department for forty-five years.

Doctor Tanguay was a former president and secretary of the Woonsocket District Medical Society and he also held membership in the Rhode Island Medical Society and the American Medical Association.

**HARRY TRIEDMAN, M.D.**, a physician and surgeon in Pawtucket for thirty-five years, died suddenly at his home on May 28, 1958.

Doctor Triedman was born in Haverhill, Massachusetts, on July 8, 1898. He was graduated from Tufts Medical School in 1922. In 1923, he came to Pawtucket to intern at Memorial Hospital.

Doctor Triedman was on the surgical staffs at Memorial, Miriam, and Roger Williams hospitals. He was a past president of the Miriam Hospital Staff Association, a Fellow of the International College of Surgeons, and the American Medical Association. He was a member of the Rhode Island, Providence, and Pawtucket medical societies.

**GEORGE WHEELER VAN BENSCHOTEN, M.D.**, well-known Providence eye surgeon and ophthalmologist, died on June 1, 1958.

Doctor Van Benschoten was born in Brooklyn, New York, on July 5, 1878. He was graduated from Northwestern Medical School, Chicago, in 1896, and he began his practice of medicine in South Bend, Indiana, coming to Providence in 1902.

Doctor Van Benschoten was head of the Ophthalmology Department of Rhode Island Hospital from 1928 to 1936. He was on the staff of Saint Joseph's, Miriam, Roger Williams, and South County hospitals.

When World War I broke out, the physician joined the Navy as a lieutenant in command of a submarine chaser. Shortly thereafter he was transferred to a submarine tender as medical officer. At the close of the war, he was stationed at the Norfolk, Virginia, Naval Hospital and was mustered out a lieutenant commander.

During World War II, he spent many nights on patrol duty off Point Judith with the volunteer coast guard auxiliary.

Doctor Van Benschoten was a member of the New England Ophthalmological Society, the American College of Surgeons, the American Medical Association, and the Rhode Island Medical Society. Doctor Van Benschoten was also a member of the Providence Medical Association and a past president of that Association.

medical units and individuals not immediately involved in military operations could be used to supplement *civil defense* operations, and

Expressed gratitude and appreciation for the long years of devoted service by *Dr. Austin Smith*, who has resigned as editor of *THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION*.

At the opening session, six state medical societies contributed a total of almost \$250,000 to the American Medical Education Foundation. The gifts were: California, \$150,305.75; Indiana, \$35,110; New Jersey, \$25,000; New York, \$19,608; Utah, \$9,977.50 and Arizona, \$8,657.50. In addition, the American Medical Association announced a contribution of \$100,000 to the Foundation.

It also was announced on the opening day of the meeting that Dr. W. Linwood Ball of Richmond, Va., A.M.A. vice president, had been appointed to the Board of Trustees to fill the vacancy caused by the recent death of Dr. Warren Furey of Chicago. Dr. Ball, who will serve on the Board until next June, said he will not be a candidate to succeed himself.

Dr. Lennie A. Coffin of Farmington, Iowa, was named the 1958 General Practitioner of the Year for his outstanding contributions to the health and civic affairs of his home community. Dr. Coffin, who is the first Iowan to receive the annual G.P. award, accepted his gold medal on behalf of "all the men who have dedicated their lives to the general practice of medicine."

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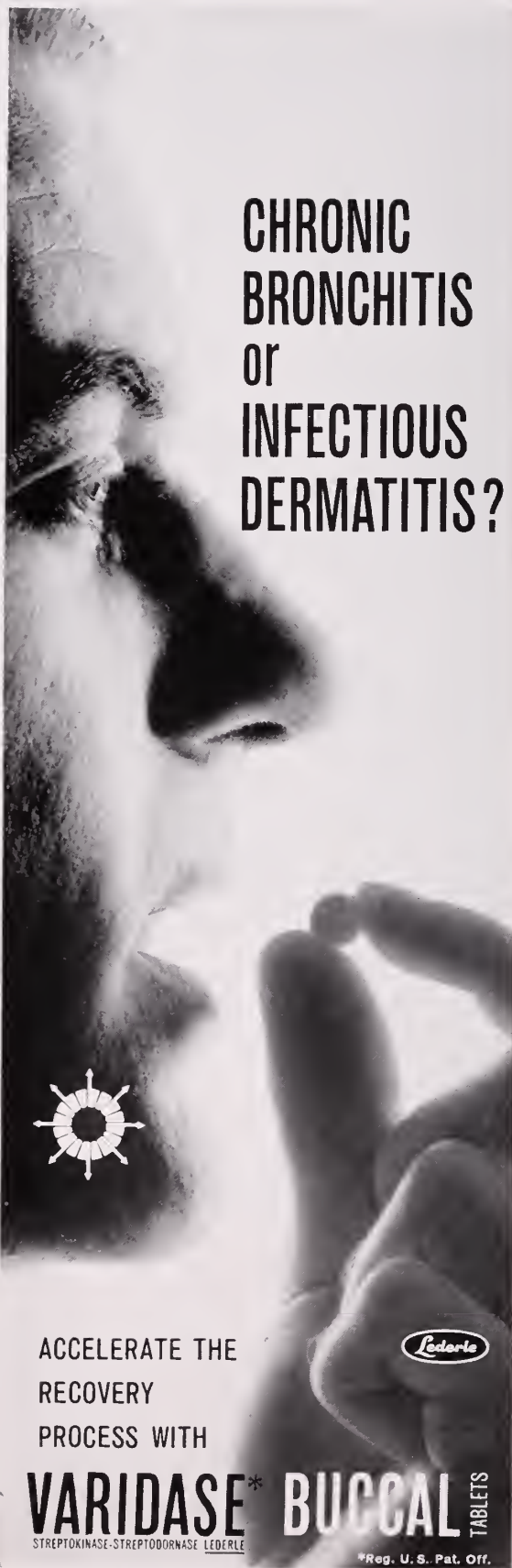
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# RHODE ISLAND



FEBRUARY, 1959

## *Medical Journal*

Volume XLII, No. 2

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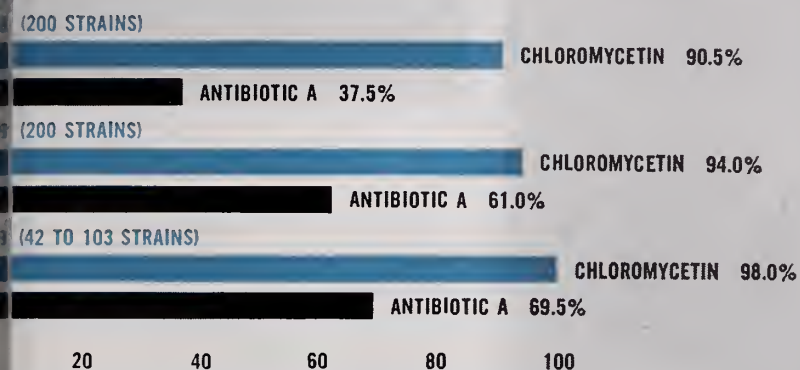
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**REFERENCES:** (1) Holloway, W. J., & Scott, E. C.: *Delaware M. J.* 30:175, 1958. (2) Roy, T. E., *et al.*: *Canad. M. J.* 77:844, 1957. (3) Markham, N. P., & Shott, H. C. W.: *New Zealand M. J.* 57:55, 1958. (4) Royer, A., in Welch, I. & Marti-Ibañez, E.: *Antibiotics Annual 1957-1958*, New York, Medical Encyclopedia, Inc., 1958, p. 783. (5) Blair, J. & Carr, M.: *J.A.M.A.* 166:1192, 1958. (6) Caswell, H. T., *et al.*: *Surg., Gynec. & Obst.* 106:1, 1958. (7) Fekety, F. *et al.*: *Am. J. Pub. Health* 48:298, 1958. (8) Godfrey, M. E., & Smith, I. M.: *J.A.M.A.* 166:1197, 1958. (9) Kessler, A. & Scott, R. B.: *J. Dis. Child.* 96:294, 1958. (10) Shaffer, T. E.: *J. Michigan M. Soc.* 57:851, 1958.

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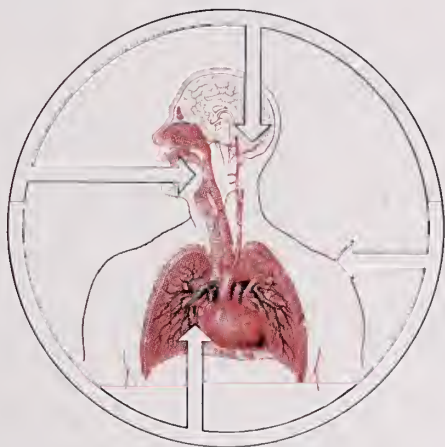


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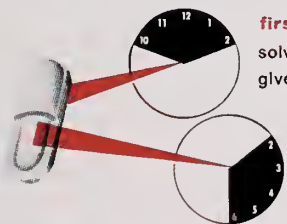
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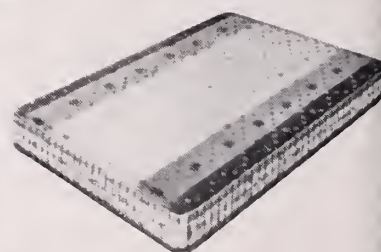
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references:

1. Griebble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958.
2. Editorial: *New England J. Med.* 258:48-49, 1958.

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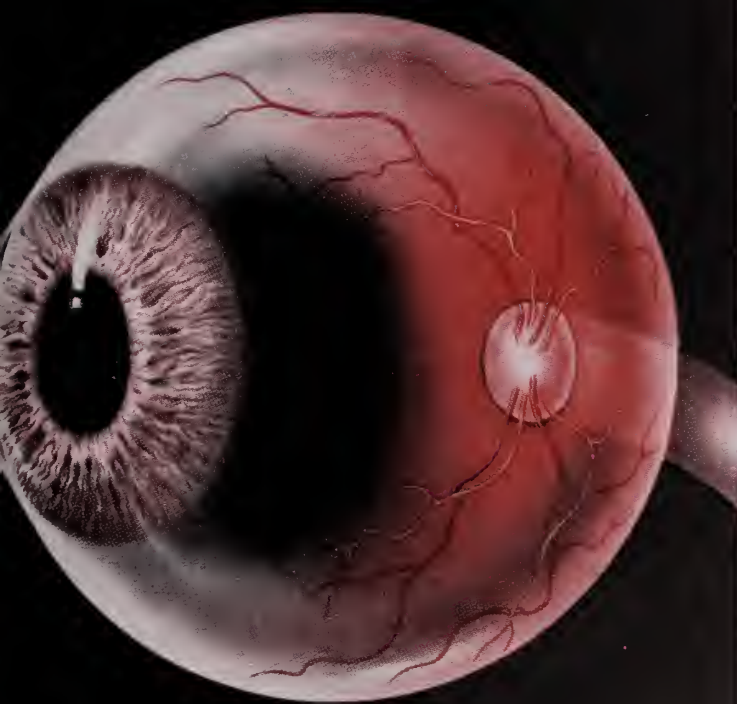
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Reinhardt, D. J.:

Delaware State Med. J. 30:1, January 1958.

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Bunn, W. H., Jr.:

Ohio State Med. J. 54:1168, September 1958.

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Herrmann, G. R., Hejtmancik, M. R., Graham, R. N. and Marburger, R. C.:

Texas State J. Med. 54:639, September 1958.

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Source: Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: The Treatment of Diabetes Mellitus, ed. 9, Philadelphia, Lea & Febiger, 1952, pp. 701-702.

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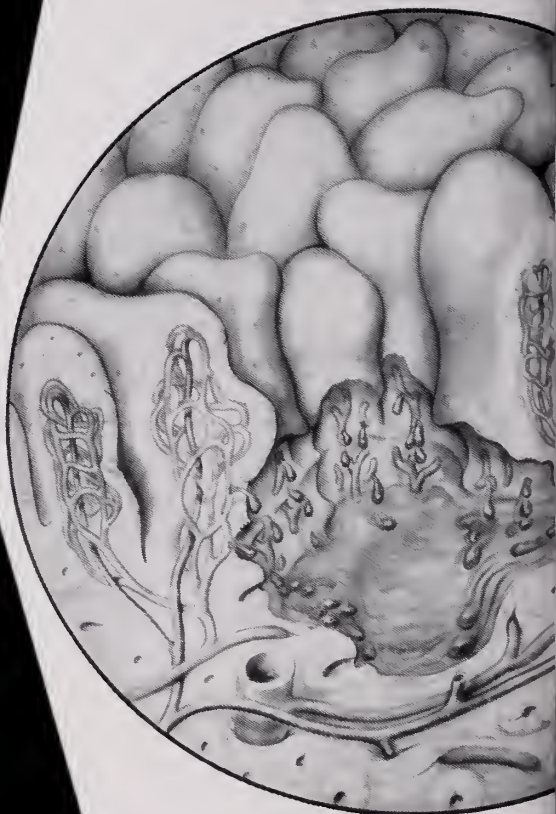
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fragile capillaries  
**in**  
**internal**  
**bleeding**



capillary hemorrhage  
in duodenal ulcer

... associated with abnormal capillary  
permeability and fragility in

**peptic ulcer**

**ulcerative colitis**

**chronic nosebleed**

**purpura**

(nonthrombocytopenic)

**hemorrhagic cystitis**

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**menorrhagia**

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## PRINCIPLES OF INSURANCE

THE COMMISSION on Medical Care Plans of the American Medical Association in its recent report issued January 17, 1959 discusses in detail the various Health Insurance programs now extant.

In outlining the Principles of Insurance, the Commission states that it "believes the proper function of Voluntary Health Insurance is to alleviate financial distress occasioned by the expenses of necessary health care."

It states further that, "It follows that health care costs that are routine, known to be recurrent, inconsequential in amount, and anticipated by the patient should not be insured because the administrative charge for the insurance must be added to the costs themselves."

Because of the distortion of the meaning of the term "insurance," some segments of the public and some physicians have come to expect underwriting carriers to provide coverages which are unsound or improper.

### *The Basic Principles of Insurance*

1. The risk must be subject to the laws of mathematical probability.
2. There must be an insurable interest.
3. There should be a large number of independent risks spread over a fairly large geographical area.
4. The risk involved must be important to the insured party.
5. There must be an element of uncertainty as to the occurrence of the risk.
6. The existence of the insurance should not have a tendency to increase the risk, or to provide an opportunity for the insured to make a financial gain.
7. The risk must be measurable financially.

It follows, therefore, that in interpreting the above principles—

1. It is necessary to be able to predict with a reasonable high degree of accuracy just how often the contingency insured against may occur.
2. The insured must be involved to the extent that he would suffer a financial loss upon the occurrence of the event against which he is insured.
3. A diversity of risks is necessary to reduce the probability that a majority of persons insured under a single program would be eligible for benefits at any one time.

4. If the contingency to be insured against is of little or no financial consequence to the insured, there is little or no need for carrying the insurance.

5. If a person knows in advance that an event is going to take place at a given time, insurance is less appropriate than budgeting so as to be able to meet the loss.

6. The existence of insurance should not result in unnecessary use of health services and/or facilities.

7. The measurement of cost is extremely important because of the direct relationship between the benefit payment and the premium.



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How well this board operates in the public interest is shown by these two facts: 1.) The Rhode Island Physicians Service Plan has the greatest percentage of persons covered of any state in the union; 2.) It operates more economically than any other plan.

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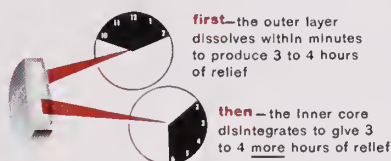
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**SEARLE**



## *The Second Dr. Murray S. Danforth Oration\**

### THE UN-UNITED HIP FRACTURE

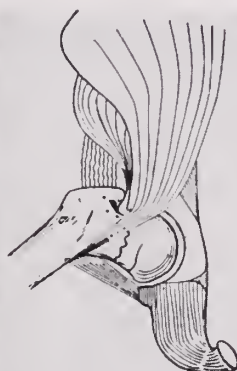
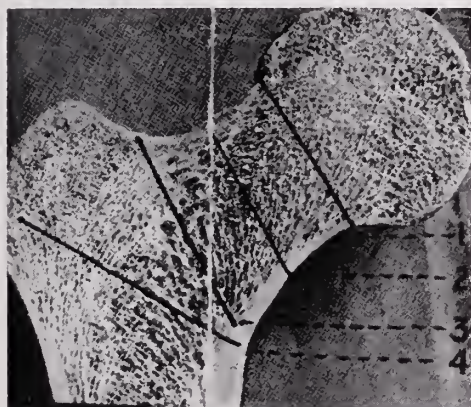
PAUL C. COLONNA, M.D.

The Author, Paul C. Colonna, M.D., of Philadelphia, Pennsylvania, Professor of Orthopedic Surgery, Emeritus, University of Pennsylvania School of Medicine; Chief, Orthopedic Department, University Hospital.

WE HAVE ALL SEEN the united neck fracture complicated by head necrosis. We have seen patients with un-united hip fracture uncomplicated by head necrosis and the un-united hip fracture complicated by head necrosis.

These problems of aseptic necrosis and non-union develop from a number of factors. All are initially from trauma. Some factors causing these

complications, we feel, can be controlled. In others, we feel baffled to explain why non-union and/or the head necrosis occur. Some cases we strongly suspect have been caused by the original vascular damage at the time of the fracture. Of course, the problem may also have been produced by inadequate treatment. It must, however, be admitted that we all have cases occasionally that go on to non-union and/or necrosis under whatever form of treatment we have employed and which, on reviewing, have received as near ideal treatment as we could offer. However, it is certain that the nearer the head the fracture occurs the more probable non-union and/or head necrosis will result (Figure 1).



Reduction by the abduction method.

FIGURES 1, 2, 3

FIGURE 1. Delber's classification is a simple regional method of identifying hip fractures; (1) subcapital, (2) transcervical, (3) cervico-trochanteric and (4) intertrochanteric.

FIGURE 2. Illustrating the essential anatomical features of the closed Whitman abduction method which stresses accurate reduction. After reduction, the limb is held in wide abduction, internal rotation and full extension by a plaster spica.

FIGURE 3. Roentgenogram illustrates non-union, neck absorption, head necrosis, shortening and outward rotation of limb.

We feel that the early adequate reduction and adequate fixation in its transcervical and cervico-trochanteric types of fractures do not often present complications of non-union and necrosis. Unquestionably, though many surgeons depend too much upon the integrity of the nail and not enough upon the roentgen evidence of bony trabeculi crossing the site of the fracture, when advising early weight

bearing, and this certainly can be the cause of future trouble.

Recognition of this fracture is as old as Hippocrates and its baffling facets have been recognized for many years, but it is only since the introduction of the X ray that one has intensively studied its complications. Unfortunately, today, even in spite of our excellent roentgen pictures, I dare say that the lateral film, both pre-operatively and post-operatively, gives far less information than is de-

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\*Delivered at Rhode Island Hospital, Providence, Rhode Island, November 6, 1958.

sired, both as to the clarity of detail and the displacement of the fragments. In addition to a helpful history and to early adequate treatment, fracture at the hip is not followed by a high percentage of solid bony union without complications. My impression, without statistics to back it up, from observation alone, would lead me to believe that the subcapital and transcervical fractures, treated in the best clinics in this country, are followed by a high percentage of non-union and aseptic necrosis. Boyd and George, in an excellent paper in 1947, reviewing 300 acute central fractures of the neck of the femur, found that only 43.6% showed a good end-result, and that the total number of follow-up patients with severe arthritic changes in the hip exceeded the number of non-unions. In fact, non-union is so high in the subcapital type fracture that I am pessimistic about obtaining bony union by any means and feel that the patient is saved time, expense, worry and non-union if some type of prosthesis is inserted or some type of reconstruction operation is done as the initial treatment. About the transcervical type, I am not so pessimistic, and feel that with ideal treatment this type of fracture gives excellent results in somewhere between 75 to 85 per cent of the cases. It must be recognized that this fracture occurs mostly in the elderly patient and that senility, previous inactivity, and frequent malnutrition is the soil upon which the fracture is grafted.

The first decision of the physician called upon to treat this type of fracture is that of saving life, and second, of being as sure as he can that the patient is a suitable candidate for an open operation, if it should be thought desirable. If an open operation is not possible or safe, we may use the closed Whitman reduction and abduction method with a long period of immobilization in a plaster spica (Figure 2). Undoubtedly, this method can and has given many good results, although statistically lower than the open operation method. The details of this method, with its many practical complexities, are not well known today and are not frequently practiced as Whitman taught. On the whole, the open operation, however, should and does give a better opportunity for anatomical reduction than the Whitman method.

When non-union is present, roentgenograms quite clearly demonstrate this, and the clinical tests of push and pull roentgenograms or placing the leg alternately in wide abduction and adduction will show whether the head moves synchronously with the shaft of the femur. Unfortunately, the decision as to the degree of aseptic necrosis present in the individual must be largely determined from the roentgenogram, both lateral and A-P, as pointed out many years ago by Santos. Films must be carefully studied to determine the type of operation best

suited for the individual problem. They can be very informative in showing the width of the joint space, the regularity or irregularity indicative of cartilage destruction and arthritic change, the displacement upward of the greater trochanter and the degree of decalcification or sclerosis of the head (Figure 3). One or all of these conditions are frequently present. The general texture of the bone structure of the hip region should also be evaluated. A laboratory test that would determine the extent of the aseptic necrosis quantitatively would help us a great deal in the selection of the best operation. Unfortunately, this is not available today. In spite of studies with isotopes, in spite of the use of the various methods employed to determine the degree of vascular damage to the head at the time of injury, there is still great difficulty in determining the percentage of viable and non-viable bone present in the head of the femur suspected of aseptic necrosis. We can visually make a rough estimate of the degree of necrosis, but can we decide that the head is viable enough to preserve or diseased enough to make us discard it at the time of operation? This is a very important decision for the surgeon to make before deciding upon operation. This inability to determine the degree of bone viability is indeed fundamental. If bone viability could be determined accurately, there are many other cases of aseptic necrosis which offer problems to the orthopaedic surgeon: those occurring during the growth period, as Legg-Perthes disease, and other causes than fracture that produce head necrosis in adult life.

### *Clinical Picture*

The clinical picture of these elderly people suffering from un-united hip fracture presents all stages of disability, from those who walk fairly well, with little pain and the aid of a cane, to those with severe pain, flexion, abduction, external rotation and contracture of the soft tissues, who require crutches or a wheel chair. As many of these fractures occur in the degenerative arthritic period of life, the adjacent knee joint must always be examined. Many times it proves to be quite a problem. Long plaster immobilization or long bed care renders the arthritic knees stiff and badly in need of rehabilitation. In the severe grade of the un-united hip with shortening of the lower extremity, we must consider the use of preliminary traction before any definitive surgery on the hip is attempted (Figure 4). If the hip has been shortened one or two or more inches over a period of years, and is in a flexed and adducted position, it is entirely too much to expect one procedure to rehabilitate the patient. Stretching of the hip and sometimes the knee, soft tissue tenotomy, traction and muscle exercises without weight bearing, must all be seriously planned before



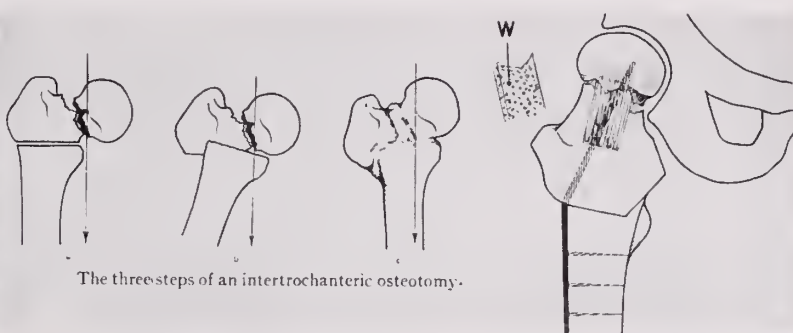
the patient is subjected to an open operation on the hip.

### *Operative Treatment*

If the decision has been reached that the necrosis of the head is of such a degree that it cannot be retained, and that we cannot hope to revascularize it, then operations such as the very valuable McMurray osteotomy (Figure 5), the Dickson geometric osteotomy (Figure 6), the Schanz operation (Figure 7), the Brackett operation (Figure 8), or the Magnuson modification can all be eliminated, as they are not applicable to the problem at hand. We must, therefore, consider some type of operation by which the necrotic head is removed, with the use of 1) a prosthesis, 2) some type of reconstruction and 3) the rarely used fusion type of operation. It hardly seems necessary to say that in the

treatment of the un-united hip, there are a great number of procedures which will assure stability and mobility. The wise surgeon tries to be familiar with all, so that he can choose the procedure best suited to his particular patient. In brief, operations fall into two categories; those in which the head can be preserved in the expectation that there will be adequate blood supply to revascularize it, and second, those that discard the head in the belief that the necrosis is so extensive that revascularization will not occur.

Within the past ten years, the prosthesis method has gained a great deal of attention. First, the Judet stem-type of prosthesis, which caused a fever of enthusiasm a few years ago, and probably still has a limited place in the patient with non-union and aseptic necrosis, must be considered (Figure 9).

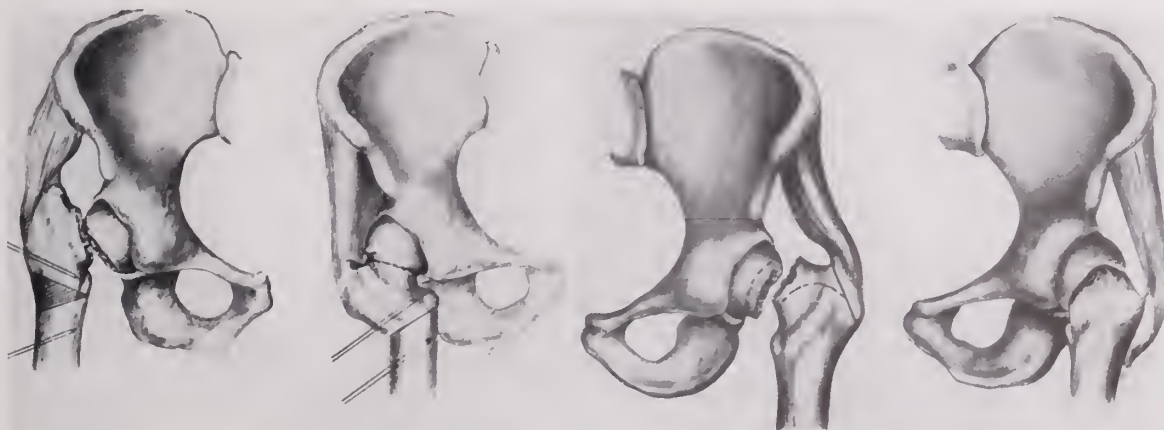


FIGURES 4, 5, 6

FIGURE 4. Roentgenogram illustration showing severe deformity. Patient had not been out of a wheel chair for a year and a half. Preliminary traction was necessary preliminary to trochanteric reconstruction operation.

FIGURE 5. Diagram illustrating principle of McMurray osteotomy.

FIGURE 6. Diagram illustrating principle of Dickson geometric osteotomy.



FIGURES 7, 8

FIGURE 7. Diagram illustrating principle of Schanz osteotomy.

FIGURE 8. Diagram illustrating principle of Brackett operation.

Second, the intramedullary type of prosthesis, of which there are many types, and which, in the past few years, has become very popular. There are many varieties of this intramedullary type of prosthesis (Figure 10). Personally, I have leaned toward the Fred Thompson type and have had most

of my experience with this (Figure 11). In the really elderly patient and in the patient who is not faced with strenuous physical activity as a wage earner, this latter prosthesis has been remarkably successful. We have reserved it almost entirely for the above type of patient, as we find that the man

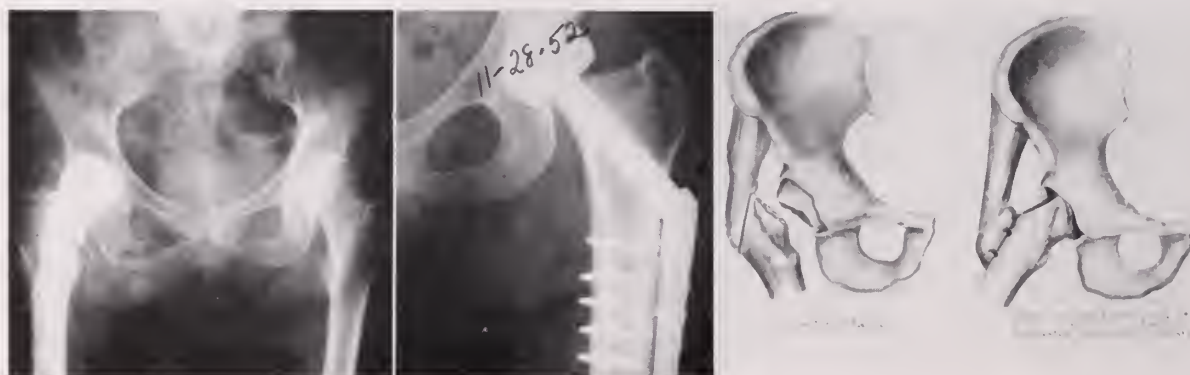
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FIGURE 9

FIGURE 9. Roentgenogram showing Judet prosthesis *in situ*. Before and after operation.



FIGURES 10, 11, 12

FIGURE 10. Roentgenogram showing Thompson prosthesis.

FIGURE 11. Roentgenogram showing Collison prosthesis. Here the tremendous shearing force may be sufficient to break screws and cause removal of prosthesis. Trochanteric reconstruction may salvage hip.

FIGURE 12. Diagram showing technique of Whitman reconstruction operation.

in his 50's or 60's, who anticipates a period of further physical activity, is not satisfied with the prosthesis. The period of convalescence for the intramedullary prosthesis is moderately short, the range of final motion is quite good for the elderly patient, 70 to 80 and up, and very important; there results an immediate degree of mobility that will permit putting on stockings and bending the hip in the various activities consistent with the age of the patient. As yet, many questions concerning erosion and post-operative pain are unanswered, and the late results in many of these patients, are not available because of the short life expectancy of these old people.

It is in the young, more active age group, that I feel the Whitman operation (Figure 12) or the trochanteric reconstruction operation, has a very real place (Figure 13). Another use for the trochanteric reconstruction operation is after the unsuccessful prosthesis. For some reason, a few patients having had a prosthesis inserted, have de-

veloped a great deal of pain on weight bearing. The reasons for the pain are hard to explain, but it has been a persistent complaint in a few cases and the surgeon is forced to remove the prosthesis. In these cases, the trochanteric reconstruction operation has been of great help.

The Whitman operation is not difficult to perform. It assures stability, a very limited amount of mobility, but it is better than an intentionally fused hip. We feel that this operation, although not as popular today as it was fifteen years ago, is still an excellent operation in selected cases. The two main difficulties seem to us to be the increased shortening of an already shortened extremity and the extreme limitation of motion, post-operatively.

It was for these reasons mainly that many years ago, we advocated removing the head and all of the projecting neck and placing the greater trochanter deeply into the acetabulum, making a new insertion for the hip abductors lower down on the thigh while the limb was held in wide abduction (Figure 14).



FIGURES 13, 14, 15

FIGURE 13. Roentgenogram showing before and after the trochanteric reconstruction operation.

FIGURE 14. Diagram illustrating technique of the trochanteric reconstruction operation.

FIGURE 15. Roentgenogram showing restoration of stability and increase in length 11 months following trochanteric reconstruction operation. See Fig. 3 for pre-operative roentgenogram.

This operation is a bit more difficult than the Whitman, but it does achieve length whenever the greater trochanter has ridden above the acetabular level, which is very common. The length of plaster immobilization, four weeks, post-operatively, is approximately the same in both operations, but we have been accustomed to trim out the plaster over the posterior aspect of the foot and leg, so that while the patient is lying on his abdomen, he may start moving the knee as early as two weeks after the operation. As stated before, the stiffness and pain in the knee has been at times a real complication in rehabilitating these people. The posterior plaster shell over the leg is, of course, strapped back into position when the patient is lying on his back.

The convalescence of these patients is important and when the plaster is removed, at the end of four weeks, a sandbag or hard pillow should be placed between the abducted legs to prevent the limbs swinging into adduction. When overhead suspension is used, the limb should be swung actively;

this sandbag maneuver will guard against redislocation during the following three or four weeks after the plaster shell is removed completely. The patient is instructed in his abductor exercises while lying on a firm mattress. We like to get the patient ambulatory and weight bearing 6 or 7 weeks after the original operation: first, using a walker, then a crutch and later a cane; many walk without any external support. We have followed many of these cases for years (Figure 15 and Figures 16a-b).

The last surgical treatment for the un-united hip fracture which will be mentioned is fusion of the hip. This is rarely indicated unless there is a severe arthritis. This may presuppose that free motion at the hip will, post-operatively, give severe pain with marked stiffness. The elderly patient, however, does not tolerate long immobilization and this is necessary to obtain solid bony union. We estimate that fusion of the hip requires between 6 to 10 months in a plaster spica for the average case and for this reason, if none other, we prefer to avoid trying to fuse these hips.



FIGURES 16a, 16b

FIGURE 16a. Post-operative roentgenogram showing Eicher prosthesis *in situ*. Persistent pain on weight bearing necessitated its removal.

FIGURE 16b. Post-operative roentgenogram 3 years following trochanteric reconstruction operation in Fig. 16a.  
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## TOXIC REACTIONS TO IODINE

ALTON M. PAULL, M.D.

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IN A RECENT ARTICLE by Sussman and Miller,<sup>1</sup> two patients were reported who developed swelling of the salivary glands following intravenous urography. In one of these patients, enlargement of the parotid gland occurred two days following the administration of 30 ml. of diatrizoate sodium (Hypaque). The other developed bilateral swelling of the submaxillary glands after the use of 20 ml. of sodium methyl glucamine diacetlyamino triiodobenzoates (Renografin). Peacock and Davison<sup>2</sup> reported that in 502 asthmatic patients, 16.1% had sufficient reactions to inorganic iodides to warrant discontinuance or sharp reduction of their medication. These reactions were physiologic ones from overdosage, or similar symptoms occurring at lower dosage due to over-reactivity on the part of the individual.

I have recently observed three patients who developed toxic reactions to iodides. In addition, four patients were observed at the Veterans' Hospital in Providence, Rhode Island, and these case histories were forwarded to me. In two patients, enlargement of the submaxillary glands occurred following the administration of a saturated solution of potassium iodide. In two others, Calcidrine,<sup>®</sup> a cough mixture containing 910 mg. of calcium iodide, anhydrous, per thirty cc. was the agent responsible for the glandular enlargement. This substance has no feature that would not pertain to other iodine preparations, except perhaps that the calcium iodide is prone to liberate iodine more readily than the other salts.<sup>3</sup>

The sudden appearance of an enlarged, tender left cervical lymph node was noted in one patient, following intravenous pyelography, and in another patient, a severe serum sickness type of reaction developed, following the use of a saturated solution of potassium iodide. More recently, I have encountered a patient who developed an erythema and pounding headaches after the use of KI.

The following are brief summaries of the patients observed who have had reactions to iodine.

### Case Number 1

H.M.: A twenty-nine-year-old white male was first seen on February 4, 1957, complaining of vague, upper anterior chest pain of three weeks' duration. These pains were constant, dull and aching in character, and not associated with exertion. He also complained of a chronic, severe, productive cough. In 1948 he was hospitalized for a spontaneous pneumothorax. No further attacks occurred, but with the development of chest pain, he was concerned over the fact that might have developed another pneumothorax.

The physical examination and laboratory data were entirely normal. An expectorant, Calcidrine, was prescribed and he was advised to discontinue smoking. The following morning, a painless swelling of both submaxillary glands developed without fever, chills or general malaise. Examination at this time revealed the submaxillary glands to be enlarged to the size of plums. The white blood count and differential examinations were normal. He was advised to discontinue the Calcidrine and within three days the enlarged glands had completely abated. The following week he resumed taking the iodine preparation and a similar course of events recurred.

### Case Number 2

A.M.: A sixty-five-year-old white male was admitted to Veterans' Hospital, Providence, Rhode Island, for treatment of chronic bronchitis and pulmonary emphysema. He had a long history of a chronic cough, productive of small amounts of colorless sputum. Physical examination revealed the patient to have clubbed fingers and an emphysematous chest. The lungs were hyperresonant to percussion and there were coarse rhonchi scattered throughout the lower lung fields posteriorly. Ten drops of a saturated solution of potassium iodide was administered in water three times during a twelve-hour period. The following day he developed swollen submaxillary glands. The iodine medication was discontinued, and within two days the swelling subsided.

### Case Number 3

L.L.: A sixty-eight-year-old white male was admitted to the Veterans' Hospital, Providence,



Rhode Island, with a similar story as in Case Number 2. The physical examination was consistent with a rather marked pulmonary emphysema. Ventilatory studies revealed an obstructive type of defect. He was placed on S.S.K.I. as in the above case. The following day he developed bilateral swelling of the submaxillary glands. Again the iodine medication was discontinued, and within two days the swelling subsided.

The following case is of additional interest because of the fact that an organic preparation was given intravenously, resulting in the enlargement of a solitary lymph node in the neck.

#### *Case Number 4*

W.B.: A fifty-six-year-old white male was admitted to the Veterans' Hospital in Providence, Rhode Island, with the chief complaint of right flank pain of several hours' duration. The following day an intravenous pyelogram was performed with diodrast. Within twenty-four hours, an enlarged, tender mass was noted in the left neck region. This was thought to be an enlarged lymph node along the sternocleidomastoid area. The iodine preparation was discontinued, and by the following day, the lymph node had disappeared.

#### *Case Number 5*

L.S.: A sixty-one-year-old white male entered the hospital because of chronic cough and wheezing of twenty years' duration which became worse the past few days. He had no seasonal incidence, but the difficulty was present throughout the year. The patient raised mucoid sputum except during acute respiratory infections, at which time it became green. He had been a heavy cigarette smoker for most of his life. Physical examination revealed a thin, dyspneic male with an audible wheeze. The chest was increased in its A-P diameter and was hyperresonant to percussion. Auscultation revealed bilateral wheezes and coarse rales at the lung bases posteriorly. The laboratory data were not remarkable except for the sputum culture which showed a *S. Albus*.

Pulmonary function studies were indicative of an obstructive ventilatory defect. Initial treatment consisted of aerosol therapy with nebulization of neo-synephrine, aminophylline suppositories, and a saturated solution of potassium iodide. On the third hospital day, the patient complained of a sore throat, and developed a temperature of 102 degrees F. Penicillin and streptomycin were given without any effect. Repeated chest X rays and throat cultures failed to show any pathologic organisms or parenchymal infiltrate to explain the fever. Anorexia, nausea and diarrhea were then noted. By the fifth hospital day the fever had risen to 103 degrees F. Physical examination at this time revealed the

additional findings of scattered papular and pustular lesions on the face and trunk, a diffusely red throat and enlarged tonsillar glands. Several stool cultures were negative.

At this time, the diagnosis of iodism was made, and sodium chloride was administered by intravenous drip. Within two days, the temperature had returned to normal and the gastrointestinal symptoms subsided.

The above case exemplifies the difficulties that may arise in establishing the diagnosis of iodine hypersensitivity in those patients who, in addition, have chronic lung disease. A general systemic reaction to potassium iodide was initially confused with superinfection of the respiratory tract. Antibiotics were given without affecting the fever, but with the occurrence of diarrhea, so that the diagnosis of a staphylococcal enteritis was entertained.

#### *Case Number 6*

T.G.: A forty-eight-year-old white male was admitted to the Rhode Island Hospital because of shortness of breath of twelve hours' duration. He had had two previous admissions for asthmatic bronchitis and pulmonary emphysema. For the past two months, he had been on a daily dose of 30 mgm. of meticorten, and in addition, epinephrine and susphrine as needed. A previous allergic workup had revealed that he was sensitive to eggs, milk, wheat, house dust, feathers and aminophyllin. Two weeks prior to the present admission, his cough became more severe and he developed tenacious yellow sputum. The physical examination revealed the temperature to be 99.2 degrees F. He was in acute respiratory distress and appeared exhausted. The chest was emphysematous, and there were inspiratory and expiratory sibilant rales scattered throughout both lung fields. The laboratory examination was not remarkable except for a moderate eosinophilia. A bronchogram showed the presence of a very mild tubular bronchiectasis involving the mesial segment of the right middle lobe. On admission to the hospital, vigorous treatment was instituted consisting of intravenous fluids, oxygen, isuprel by nebulization, reassurance, and a saturated solution of potassium iodide. The patient improved but developed a severe pounding headache which came on shortly after receiving the second dose of K.I. In addition, it was noted that he developed a marked flushing of his face, neck and upper part of his body. On further questioning, it was elicited that he had had similar reactions in the past and had been advised not to take any iodine preparations.

#### *Case Number 7*

B.F.: A thirty-six-year-old white male developed an upper respiratory infection with cough. Because of the increasing severity of the cough, he

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took some cough medicine (Calcidrine) that I had previously prescribed for his wife. He claims he took five or six teaspoonsful. The following day, I was called to see the patient when he became alarmed by the sudden appearance of "enlarged glands" beneath his jaw. On examination, I found him to have enlarged tender submaxillary and slightly enlarged and tender parotid glands. He was advised to discontinue the cough mixture and within three days the glandular enlargement subsided.

### Discussion

Iodide preparations may be divided into three groups:

1. Inorganic iodides, such as saturated solution of potassium iodide and syrup of hydriodic acid.
2. Organic preparations, such as Organidin and Amend's solution.
3. Mixture of iodide with other drugs such as Quadrinal and Mudrane.

Iodine is readily absorbed from the gastrointestinal tract as iodide, following which it is mainly concentrated in the extracellular spaces with greatest concentration in the thyroid gland, mucous glands of the stomach, the salivary glands and in the lactating breasts of pregnant females.<sup>4</sup> Small amounts of iodides enter the red blood cells and may exchange with chlorides in the fixed tissue cells.

Excretion of iodide is chiefly by the kidney. The rate of clearance for iodide is much higher than for the other halogens.<sup>5</sup> Furthermore, in man, the renal excretion of iodide is uninfluenced by the amount of chloride demanding excretion. Attention should also be drawn to the fact that the symptoms of iodism are more apt to occur in the presence of impaired renal function.

The iodides exert few pharmacological actions. Even after intravenous administration of large amounts, there is no observable specific response. Neither the central nervous system nor the circulation is affected. The action of iodide on inflammation and diseased tissues is imperfectly understood.

Iodine reactions can generally be placed in two categories. First, there are the toxic signs and symptoms due to acute and chronic overdosage. Acute poisoning from an initial dose of the iodide is relatively rare, and even after intravenous injections, reactions are seldom seen. An occasional individual, however, may show a marked sensitivity; therefore, before iodide salts or organic iodine preparations are given by the intravenous route, the tolerance of the individual should be determined. The onset of acute iodide poisoning may occur immediately or several hours after the ad-

ministration of the salt. Angioneurotic phenomena are the outstanding symptoms and edema of the larynx may lead to suffocation. Multiple cutaneous hemorrhages of the skin and mucous membranes may occur, but this is rare.

Chronic iodine poisoning, or so-called iodism, usually results from therapy with inorganic iodide compounds, and will occur in all persons if the dose is high enough. The symptoms include an unpleasant brassy taste, burning in the mouth and throat, with soreness of the teeth and gums and swelling of the eyelids and coryza. The person with a mild form of iodism presents the picture simulating an acute "head cold." Pulmonary edema may occur, particularly in the susceptible cardiac patient with early failure of the left ventricle. Inflammatory reactions involving the salivary glands, pharynx, larynx and tonsils may appear. Skin lesions are common. They usually are mild, acneiform in character, and distributed in the seborrheic areas. Rarely, a severe and sometimes fatal skin eruption (ioderma) may occur after prolonged use of iodides. Cachexia, fever, and depression have all been included in the clinical state known as "iodism."

In the second category are the signs and symptoms due to true hypersensitivity to the drug. In 1940, Barker and Wood<sup>6</sup> reported seven cases of severe iodism from the administration of iodides for hyperthyroidism. In addition to many of the symptoms mentioned above, the patients had fever, eosinophilia, and in one case, jaundice. In 1945, Rich<sup>7</sup> reported a patient with hyperthyroidism, treated with Lugol's Solution, who developed periarteritis nodosa. Davis and Saunders<sup>8</sup> reported a patient with purpura resulting from the use of potassium iodide. In 1947, Bechel<sup>9</sup> reported three cases of bullous ioderma, apparently originating from the administration of iodinated table salt and clearing with its discontinuance. In 1949, Ehrlich and Seifter<sup>10</sup> reported a patient who developed thrombotic thrombocytopenic purpura following the administration of kelp containing iodine. Other authors have reported patients who developed periarteritis nodosa following the use of iodides. Weber-Christian's disease has been attributed to iodide sensitivity.<sup>11</sup>

To the above two categories of reactions, one more might be added. In 1953, Morgan and Trotter<sup>12</sup> reported two cases of theirs where myxedema occurred, apparently from the use of iodides. They concluded that myxedema rarely occurred with iodide administration, since the glands seemed to become tolerant of high doses of iodine and to evade the normal blocking actions. In 1956, Skagg<sup>13</sup> reported a case of transient myxedema, due to potassium iodide which cleared with discontinuance of the drug.



The occurrence of iodism, particularly of the submaxillary and parotid glands, is very interesting, and of several theories that of an anaphylactic response is the most likely.<sup>3</sup> The recent demonstration that cortisone alleviates iodism is in accord with, but does not prove a hypersensitivity basis for iodism.<sup>14</sup>

Enlargement of the salivary glands has been noted in a variety of diseases. Several authors have recently commented on the occurrence of asymptomatic enlargement of the parotid glands in patients with alcoholism and cirrhosis; the common denominator being malnutrition.<sup>16,17</sup> It has also been claimed that salivary gland swelling may occur in rheumatic diseases.<sup>18</sup> Other causes of salivary gland enlargement include hyperglobulinemic purpura of Waldenstrom, the Plummer-Vinson syndrome, pernicious anemia and Reiter's syndrome. Local disturbances include tumors, infection, calculi and ill-fitting dentures.<sup>19</sup>

The symptoms of iodism disappear spontaneously within a few days after the omission of iodide medication. Treatment, therefore, consists of omitting the drug and using supportive measures, as determined by the particular symptoms. Abundant fluids and increased sodium chloride may be of assistance in hastening iodide elimination. Iodism is only rarely fatal.<sup>6</sup> More recently, it has been shown that cortisone is helpful in alleviating the symptoms of severe iodide hypersensitivity and may also prevent the development of severe iodism.<sup>15</sup>

### SUMMARY

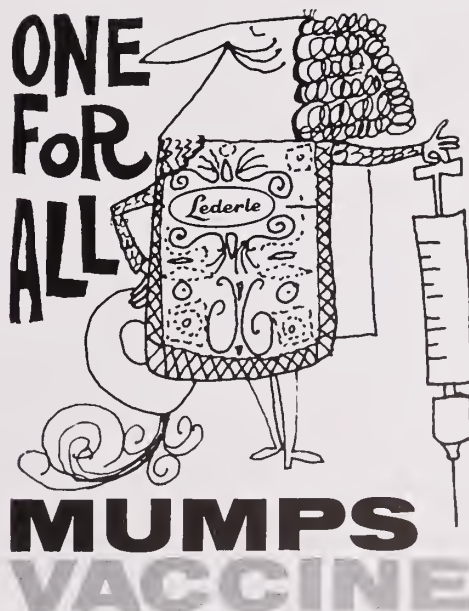
Attention is drawn to the various toxic manifestations resulting from the use of iodides, and particularly the occurrence of enlarged salivary glands (Iodide Mumps). Awareness of the occurrence of salivary gland enlargement from iodide ingestion may save the patient considerable expense and the physician embarrassment.

### BIBLIOGRAPHY

- <sup>1</sup>Sussman, R. M.; and Miller, J.: Iodide "Mumps" after Intravenous Urography, *N.E.J.M.*, 255:433-434, 1956
- <sup>2</sup>Peacock, L. B.; and Davison, H. M.: Observation on Iodide Sensitivity, *Annals of Allergy*, 15:158-164, March-April, 1957
- <sup>3</sup>Personal communication
- <sup>4</sup>Goodman, L. S.; and Gilman, A. Z.: *The Pharmacological Basis of Therapeutics: A Textbook of Pharmacology, Toxicology and Therapeutics for Physicians and Medical Students*. Second edition. 1831 pp New York: Macmillan P 824, 1955
- <sup>5</sup>Honour, A. J.; Myant, N. B.; and Rowlands, E. N.: Secretions of Radioiodine in Digestive Juices and Milk in Man, *Clin. Sc.*, 11:447-462, November, 1952
- <sup>6</sup>Barker, W. H.; and Wood, W. B.: Severe Febrile Iodism during the Treatment of Hyperthyroidism, *J.A.M.A.*, 114:1029-1038, March 3, 1940
- <sup>7</sup>Rich, A. R.: Hypersensitivity to Iodine as a Cause of Periarthritis Nodosa, *Bull. Johns Hopkins Hosp.*, 77:43,

1945

- <sup>8</sup>Davis, W. C.; and Saunders, T. S.: Purpura due to Halogens, *Am. Pract.*, 4:43-44, September, 1949
- <sup>9</sup>Bechel, P. E.: Role of Iodized Table Salt in Iodema, *J. Invest. Dermat.*, 8:409, 1947
- <sup>10</sup>Ehrlich, W. E.; and Seifter, J.: Thrombotic Thrombocytopenic Purpura Caused by Iodine, *Arch. Path.*, 47:446-449, May, 1949
- <sup>11</sup>Simon, S.: Sudden Death following Intravenous Administration of "Diodrast," *J.A.M.A.*, 138:127-128, September 11, 1948
- <sup>12</sup>Morgan, M. E.; and Trotter, W. R.: Two Cases of Myxedema Attributed to Iodine Administration, *Lancet*, London, 265:1335-1337, December 26, 1953
- <sup>13</sup>Skagg, J. T.: Transient Myxedema Produced by Prolonged Ingestion of Saturated Solution of Potassium Iodide (not published), Presented at American Academy of Allergy, February, 1956
- <sup>14</sup>Waugh, William A.: Use of Cortisone by Mouth in Prevention and Therapy of Severe Iodism, *A.M.A. Arch. Int. Med.*, 93:298-303, February, 1954
- <sup>15</sup>Park, F. R.; Crank, R. T.; and Crank, G. E.: Prevention of Iodism in Bronchography by Use of ACTH: Case report, *Dis. of Chest*, 24:219, 1953
- <sup>16</sup>Wolfe, S. J.; Summerskill, W. H. J.; and Davidson, C. S.: Parotid Swelling, Alcoholism and Cirrhosis, *N.E.J.M.*, 256:11, March 14, 1957
- <sup>17</sup>Sandstead, H. R.; Koehn, C. J.; and Sessions, S. M.: Enlargement of the Parotid Gland in Malnutrition, *Am. J. Clin. Nutrition*, 3:198, May-June, 1955
- <sup>18</sup>Seifert, G.; and Geiler, G.: Salivary Glands and Rheumatic Disease, *Germ. Med. Month.*, 3:87-90, 1958
- <sup>19</sup>Furstenberg, A. C.; and Blatt, I. M.: Intermittent Parotid Swelling due to Ill-Fitting Dentures—An Entity; Its Diagnosis and Treatment, *Laryngoscope*, 68:1165-1180, 1958



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## THE TELEPHONE THAT NEVER SLEEPS

*Presidential Address\**

JOSEPH G. McWILLIAMS, M.D.

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The Author, *Joseph G. McWilliams, M.D., President, 1958, the Providence Medical Association.*

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THE BYLAWS of this Association state very specifically that one of the duties of the president of the Providence Medical Association shall be to "deliver before the Association at the annual meeting an address with special reference to the work and needs of the Association."

As far as I know, the Association has no particularly pressing needs, and also as far as I know you have been made pretty much aware of the work of the Association in the past year through your attendance at our monthly meetings or through reading of the minutes of these meetings as published in the RHODE ISLAND MEDICAL JOURNAL. Because of this situation, one in my position has to cast about a little bit to find a subject that might be interesting and still come within the mandate of the bylaws by having some reference to the needs and work of the Association. Some of my predecessors in this office have been of the crusading type and have spent a good deal of work and conscientious effort in bringing before you some problem having to do with reform or needed change in some aspect of the work of the Association. Believe me, I am not a crusader, never have been and probably never will be.

I would like to bring before you an aspect of the work of this Association which has received, at least to the present time, very little publicity and acclaim. Certainly you are all familiar with the Medical Bureau of the Providence Medical Association—JACKSON 1-2331. But just how familiar are you with the specific work which is carried out down below us in the basement of this building?

The Medical Bureau was opened in September, 1949, after several months of careful planning, by a committee headed by Doctor John G. Walsh and composed of Doctors William P. D'Ugo, E. Victor Conrad, Nathan Rakatansky and Henry S. Joyce, working with the executive secretary of the Association, Mr. John E. Farrell. The latter had actually

originally broached the idea in 1939, but it was not considered feasible at that time because of the existence of private facilities. A poll taken in 1946 showed that a majority of the members wanted a telephone secretarial system run by the Association, but several more years were needed to get the Bureau into actual operation.

I wish all of you would do as I did, a couple of weeks ago, and stop by the Bureau's center downstairs. I am sure that you would be astounded, amazed and fascinated as I was at the work which is being done there. I happened to go in on a Wednesday afternoon, which is a busy time, and got an idea what these girls go through. I am sure that if I had to work in that atmosphere for more than just a few minutes, they would have to find some place for me in one of the wings over at the Chapin Hospital. These girls, however, seem to take it in their stride and take these calls all in the business of the day. Certainly it is to their credit, the credit of our Association and the committee responsible for instituting this Bureau, and especially to Mr. Farrell, who perhaps was the spark plug in starting this activity and certainly has done a lot in helping to maintain its good work and helping to carry on its high standards.

Just a little bit about the physical set-up of the Bureau. The actual switchboard allows for five positions—in other words, five operators can be on duty at one time in order to handle the flow of calls coming in. Originally it was only for three positions, and seven operators covered the needs of 165 physicians. Now we employ seventeen operators and serve 383 doctors. It may surprise you to know that they average about 2750 calls a day of all types, incoming calls, referrals, etc., and on Wednesdays and some other days, particularly following holidays, the total rises to as high as 3500 calls in one twenty-four hour period.

The volume of this work is almost beyond comprehension unless one actually sees it being carried out. The handling of this work is done expertly and with such ease that it seems simple and routine. Yet each one of these calls is a very definite problem and challenge to the operators twenty-four hours a day, day in and day out. This is a great service to you—you are entitled to it for it is your

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\*Presidential address to the Providence Medical Association at its 112th Annual Meeting, at the Rhode Island Medical Society Library, January 5, 1959.

Bureau—but more so is it a great service to the public, which knows it can call upon this organization of ours at any time with the knowledge that its immediate medical problems, real or fancied, will be handled with dispatch.

The actual number of operators on duty at the same time is varied according to the work load. This is based a good deal upon past experience. Mrs. Beagan, who is the supervisor and has been with us since the inception of the service almost ten years ago, has very adequate and illuminating statistics which enable her to tell just how many girls she is going to need on duty. It takes about a year to train one of these operators so that she can handle your individual needs and also take care of the public at large when it calls into the Bureau directly. As I understand it, if a new girl is taken on, she is more or less on probation for about three months. Most of the operators have had former work with the Telephone Company and at least know something about the mechanics of the switchboard operation but certainly very little about this special type of service. According to Mrs. Beagan, who used to be with the Telephone Company, there is no comparison. Some of the girls just “can’t take it” and have to go on to some other pursuit. This, to me, is understandable. I am sure I couldn’t have taken it for even a day at a time. There is not a great deal of actual physical work, but most of the girls are fatigued at the end of the day; and this is believable since they are under a good deal of strain. They feel their responsibility quite definitely and certainly discharge this responsibility in practically all instances with commendable results.

At the present time we have 383 doctors who subscribe to the Medical Bureau, and in addition to this we have a few who use the listing in the telephone book: “If no answer, call JACKSON 1-2331.” I think it is interesting to note that the Bureau has a direct line with the Providence Police Department central office, and through this direct connection we are then able to contact the rescue squad and, of course, the police on detail throughout the city. There has been a wonderful spirit of co-operation between the police and fire departments with our Bureau, and I think we can consider this a more or less admirable set-up. There are also direct lines to the five major hospitals which provide an important link in the complete emergency coverage of the entire city. I think the designation of “the telephone that never sleeps” is an excellent description of the Medical Bureau.

Emergency calls have been in the past, and will continue to be, a big problem for the Bureau. When the Bureau was first started, several methods were attempted in trying to work out emergency coverage. One of these was to request doctors to take emergency calls in certain areas of the city, divided

off arbitrarily into zones; but this did not work out too well. The other was to have a certain doctor on call one day of the month, at which time he would be obligated to take emergency calls, but there were times when this was not feasible. More recently the younger men entering into practice have been encouraged to take on this work, and indeed I know that the taking of emergency calls from the Bureau has, in many instances, provided a good nucleus for a successful practice for a young physician.

In a recent survey of similar facilities in nine cities carried out by Mr. Farrell, it was noted that our Medical Bureau stands out as one of the finest in the nation operated under the supervision of a medical society. We seem to have a better-organized program and make more calls monthly than telephone exchanges in other comparable areas, and our emergency call system seems to be much more effective. In the past years Mr. Farrell has made several surveys of emergency calls made by the public to the Medical Bureau. One of these has been published and is familiar to you. Another was a special report to the Executive Committee made in October of 1956. These reports indicate what you and I know quite well, that most emergencies are not emergencies, but nevertheless we all know that we more or less have to take this sort of thing in our stride. The one true emergency that we answer and take care of, many times justifies the other non-emergencies, which we are obliged to take care of. The operators, after their many years of experience, are pretty sharp in detecting and ferreting out by careful questioning just what the actual situation is. Of course, they are lay people and are not qualified to decide entirely what constitutes a true emergency. Many times, because of repeaters, and from past experience, a police car is asked to go and actually investigate. In many instances these are found to be nuisances or drunks, etc. If there is any question in their minds, of course, the operators contact a doctor. Often the physician by talking to the caller on the telephone can resolve the problem, but in many instances a house call is necessary. The actual financial return from these calls leaves much to be desired, but I think it is important to point out that these calls are made by the volunteer physicians with the idea that their being paid is entirely secondary.

The unwritten records of our Medical Bureau could furnish some very interesting reports of behind-the-scene service that never won any particular public recognition or acclaim other than that these girls on the job, and the doctors answering the calls and, in many instances, the rescue squads, have a personal satisfaction in knowing that a job was well done and that perhaps someone's life was saved. There are many cases on file that could be cited here, but we usually treat the unusual with

## TRAUMATIC RUPTURE OF THE NORMAL SPLEEN

WARREN W. FRANCIS, M.D., AND JORGE BENAVIDES, M.D.

The Authors. *Warren W. Francis, M.D., Assistant Surgeon, and Jorge Benavides, M.D., Assistant Resident Surgeon, Rhode Island Hospital, Providence, Rhode Island.*

**A**LTHOUGH THE DIAGNOSIS of traumatic rupture of the normal spleen is usually fairly obvious, it may on occasion be obscure. In those occasional cases, diagnostic peritoneal tap may be of considerable assistance.

The experience at the Rhode Island Hospital has been reviewed, a case in which diagnostic peritoneal tap was of lifesaving value will be presented, and the technique will be described.

### *Experience at the Rhode Island Hospital*

**Material** • Over a twelve-year and eight-month period extending from January, 1946 through August, 1958, thirty patients with traumatic rupture of the normal spleen were admitted to the Rhode Island Hospital.

**Age and Sex Distribution** • As shown in Table 1, males outnumber females by an 11 to 4 ratio, and 56% of the patients were under the age of twenty. The sex distribution is similar to other published reports, but the age distribution is different in that most other series show the peak incidence to be in the second to fourth decades.

TABLE 1  
A. Sex Distribution

Males	22 patients
Females	8 patients

B. Age Incidence

Years	0-10	11-20	21-30	31-40	41-50	51-60	61-70
No. of cases	9	8	2	2	5	3	1

**Type of Trauma** • Table 2 shows 93% of the cases associated with non-penetrating trauma. It is also interesting to note that only six cases, or 20% of the total, were associated with auto accidents.

**Signs and Symptoms** • The clinical picture associated with traumatic rupture of the spleen is well known.<sup>6,7,8,11</sup> Abdominal pain associated with tenderness and spasm involving primarily the left upper quadrant was present in a high percentage of the cases in this series. Sixteen patients, or 53%,

complained of shoulder pain, while twenty-two patients, or 73%, showed some evidence of shock. In only one patient was a mass palpable.

TABLE 2  
Type Trauma

Non-penetrating	28 patients
Penetrating	2 patients
(Auto Accidents)	6 patients

**Laboratory Aids** • As shown in Table 3, a high percentage of the cases had a white blood count over 10,000, while only nine patients, or 30%, had a hemoglobin below 10 grams.

TABLE 3  
Laboratory Aids

White blood count	Above 10,000	Below 10,000	Not Done
	24 patients	2 patients	4 patients
Hemoglobin	Below 10 grams	Above 10 grams	Not Done
	9 patients	20 patients	1 patient

**X ray** • X-ray evidence of an elevated left leaf of the diaphragm, obliteration of the splenic shadow with serration of the greater curvature of the stomach, or a left upper quadrant mass with or without displacement of abdominal organs may suggest injury to the spleen.<sup>6,10</sup> Eight cases in this series showed roentgenological signs suggestive of ruptured spleen.

**Diagnostic Peritoneal Tap** • Five taps were done in this series. In three cases, blood was obtained. In these three, the procedure made the diagnosis. Unfortunately, the finding was temporarily disregarded in two of these cases until the patient's condition deteriorated to a point where diagnosis was even more obvious. This procedure will be discussed more fully later.

**Time of Rupture** • Forty-eight hours has been arbitrarily set as the time dividing rupture of the spleen into the primary and delayed type.<sup>9</sup> In this series, five cases were of the delayed type, giving a ratio of 5 to 1, which is consistent with most other published reports.<sup>1,4,9,14</sup>

**Associated Injuries** • These are listed in Table 4. As is usually the case, rib fractures were the most common associated injury. It is also interesting to note that renal injuries were less frequent in this series than in some other reports.<sup>11</sup>



TABLE 4

Associated Injuries	Number of Patients
Rib fractures	6
Renal	3
Hepatic	2
Lung	2
Head	1
Colon	1
Stomach	1
Extremity fracture	1
Diaphragm	1

**Therapy** • There is little doubt that splenectomy is the treatment of choice for rupture of the spleen. This is borne out in this series by the fact that the only two deaths occurred in those patients not operated upon. Of the twenty-eight patients treated surgically, twenty-five had splenectomies, and three merely had repair of the splenic injury. The latter three recovered, but this procedure is not recommended. Thirteen of the operations were carried out through left-rectus incisions, while eleven were done through sub-costal incisions. Various incisions were used in the four other cases.

**Morbidity** • The complications associated with therapy are listed in Table 5. None was serious.

TABLE 5

Post-operative Complications	Number of Patients
Fever	16
Paralytic ileus	8
Pneumonitis	5
Atelectasis	2
Wound infection	2
Thrombophlebitis	2

**Mortality and Analysis of Deaths** • There were two deaths in the entire series for an over-all mortality rate of 7%, but there were no deaths in those 28 operated cases, an operative mortality of 0%.

One fatal case was a forty-three-year-old man with multiple severe injuries to the ribs, left chest, liver and spleen. The other was a sixty-eight-year-old man admitted with fractured ribs and fracture of the transverse process of the second lumbar vertebra. He was in good condition on admission, but suddenly went into shock and died approximately twelve hours after admission. Post-mortem examination revealed rupture of the spleen, with 2000 cc. of blood in the peritoneal cavity. The diagnosis was missed in this case and certainly could have been made if a diagnostic peritoneal tap had been done.

#### Case Presentation

**Rhode Island Hospital #548903** • A sixty-year-old white female was admitted in September, 1955, with sudden, severe abdominal pain of one hour's duration, associated with sudden weakness and collapse. About one week prior to admission, patient had a slight fall, contusing her left chest. She had been treated symptomatically at home but had been up and about. During the four days prior to admis-

sion, she had noted increasing shortness of breath and weakness. She was seen by her doctor at that time who found her blood pressure to be 180/110. Past history revealed that she had had a spontaneous subarachnoid hemorrhage five years previously and had known hypertensive cardiovascular disease for which she had been receiving Raudixin. It was of interest that one year prior to admission, she had an X ray of her upper gastrointestinal tract for sudden episodes of abdominal pain. This had been reported as negative.

When the patient arrived in the Accident Room, she was in shock and no blood pressure was obtainable, but heart sounds were of good quality. She was given immediate blood transfusions and other supportive therapy with some improvement, her blood pressure being 126/78 and a pulse of 100 upon arrival on the ward. She was responsive at that time but very lethargic, and complained of no pain. Physical examination revealed her heart to be enlarged to the left, with a harsh systolic apical murmur and a regular rhythm. Her abdomen was obese, somewhat distended; no organs or abnormal masses could be felt; hypoactive bowel sounds were present; there was no fluid wave or shifting dullness, tenderness or spasm. Rectal examination was normal, and stool guaiac was negative. Good pulses were felt in both feet. There was no edema or cyanosis. Neurological examination was normal. *Lab Data*—Microhematocrit 25%, WBC 19,350 with 80% polys, urinalysis normal, BUN 22 mgm./%, CO<sub>2</sub> 13 meg./liter, serum amylase 57 (normal value up to 50 in this laboratory). Chest and abdominal X rays were normal.

Following admission, her condition remained about the same, very lethargic, pale, blood pressure remaining about 120/80. In view of her past history, the differential diagnosis included a cerebral vascular accident, as well as hemorrhagic pancreatitis, mesenteric thrombosis, and dissecting aneurysm of the aorta. About six hours after admission, a diagnostic peritoneal tap was performed in the left lower quadrant and 15 cc. of grossly bloody fluid, which did not clot, were obtained. She was taken to the Operating Room; under endotracheal anesthesia, a splenectomy was performed for a lacerated spleen with evidence of an old subcapsular hematoma. Approximately 1,500 to 2,000 cc. of blood were present in the peritoneal cavity. Post-operative course was uneventful except for a superficial thrombophlebitis. She was discharged on the eleventh post-operative day.

This case represents a situation where diagnostic peritoneal tap clarified an obscure picture and allowed immediate, lifesaving surgery.

#### Discussion

The problems of diagnosis and therapy in pa-

*concluded on next page*

tients with traumatic rupture of the spleen have been reviewed on many occasions.<sup>2, 6, 7, 8, 11, 13</sup> There is no disagreement that the proper treatment is surgical, and the proper surgical treatment is splenectomy. Conservative therapy carries a high mortality rate. The two patients in this series treated without operation died.

Diagnostic peritoneal tap has been mentioned in the literature on several occasions in regard to diagnosis of patients with abdominal trauma.<sup>3, 4, 5, 6, 12, 13, 14</sup> Five such taps were performed in this series. The case presented above is the most dramatic. In two of the cases, no blood was obtained, but the patients were operated upon because they exhibited the other signs and symptoms of ruptured spleen. At operation, blood was localized in the perisplenic area. This accounted for the negative taps. In the two remaining cases, positive abdominal taps were temporarily disregarded, and operation was delayed.

**Technique** • The urinary bladder is emptied, and the patient is placed in semi-Fowler's position. The abdomen is prepared with an appropriate antiseptic agent, a small skin wheal is raised in the left lower quadrant with 1% novocain. A number 18 or 19 spinal type needle attached to a syringe containing a small amount of novocain is used to perform the tap. As the peritoneum is entered, a small amount of novocain is injected in an effort to displace any intestine which may be close to the abdominal wall. The left lower quadrant has been the site of choice for this procedure because intraperitoneal structures are more mobile in this area. There have been no complications encountered by the authors in many such procedures. A positive tap proves intraperitoneal bleeding, whereas a negative tap is of little value; operation should never be deferred because no blood was obtained on peritoneal tap when the clinical signs point to splenic injury.

### SUMMARY

1. The experience at the Rhode Island Hospital in dealing with traumatic rupture of the normal spleen has been reviewed. An over-all mortality of 7% was found, with an operative mortality of 0%.
2. A case in which diagnostic peritoneal tap was of assistance has been presented.
3. The diagnostic peritoneal tap is advocated as an aid in obscure cases.
4. The technique is described.

### REFERENCES

- <sup>1</sup>Bailey, H. A.; and Schreiber, S. L.: Delayed Rupture of the Spleen, *Am. J. Surg.*, 66:4-14, 1944
- <sup>2</sup>Byrne, Ralph V.: Splenectomy for Traumatic Rupture with Intra-abdominal Hemorrhage. Report of One Hundred and One Cases, *Arch. Surg.*, 61:273-285, 1950
- <sup>3</sup>Byrne, R. V.: Rupture of Spleen, *Surg. Gyn. Obst.*, 93:247-249, 1951

- <sup>4</sup>Fultz, C. Thomas; and Altemeier, William A.: Delayed Rupture of the Spleen After Trauma, *Surgery*, 38:414-422, 1955
- <sup>5</sup>Glas, W. W.; Musselmen, M. M.; and Campbell, D. A.: Hepatic Injuries, *Am. J. Surg.*, 89:748-752, 1955
- <sup>6</sup>Knopp, Lawrence M.; and Harkins, Henry N.: Traumatic Rupture of the Normal Spleen, *Surgery*, 35:493-500, 1954
- <sup>7</sup>Larghero, Ybarz P.; and Giuria, P.: Traumatic Rupture of the Spleen; Statistical Data on 18 Cases, *S.G. & O.*, 92:385-404, 1951
- <sup>8</sup>Mansfield, Robert D.: Traumatic Rupture of the Normal Spleen, *Amer. J. Surg.*, 89:759-768, 1955
- <sup>9</sup>McIndoe, A. H.: Delayed Hemorrhage Following Traumatic Rupture of the Spleen, *Brit. J. Surg.*, 20:249-268, 1932
- <sup>10</sup>O'Neill, James F.; and Rousseau, J. P.: Roentgenologic Examination of the Abdomen as an Aid in the Early Diagnosis of Splenic Injury, *Ann. Surg.*, 121:111-119, 1945
- <sup>11</sup>Parsons, L.; and Thompson, J. E.: Traumatic Rupture of the Spleen From Non-penetrating Injuries, *Ann. Surg.*, 147:214-223, 1958
- <sup>12</sup>Schaer, S. M.; Dziob, J. M.; and Brown, R. U.: Bile Duct Rupture From External Blunt Trauma, *Am. J. Surg.*, 89:745-747, 1955
- <sup>13</sup>Wright, L. T.; and Prigot, A.: Traumatic Subcutaneous Rupture of the Normal Spleen, *Arch. Surg.*, 39:551-576, 1939
- <sup>14</sup>Zabinski, Edward J.; and Harkins, Henry N.: Delayed Splenic Rupture: A Clinical Syndrome Following Trauma. Report of Four Cases With an Analysis of One Hundred and Seventy-seven Cases Collected From the Literature, *Arch. Surg.*, 46:186-213, 1943

## THE UN-UNITED HIP FRACTURE

*concluded from page 95*

### SUMMARY

We have attempted a very brief review of some of the main operations available for treating the un-united hip fracture and to point out the advantages and pitfalls of these various procedures. In closing, it should be remembered that non-surgical methods have been stressed very little, but that they must be mentioned when we are discussing the whole problem. Occasionally, one sees a patient who gets along quite well with crutches or even with a wheel chair, so that conservative care must continue to have a place in the treatment of these patients.

### REFERENCES

- Boyd, H. B. & George, I. L., *Jour. B. & J. Surg.*, 29, 13, 1947 (Jan.).
- Brackett, E. G., *Boston M. & Surg. J.*, 192, 1118, 1925.
- Colonna, P. C., *Jour. B. & J. Surg.*, 17, 110, 1935.
- Colonna, P. C., *Jour. B. & J. Surg.*, 21, 701, 1939.
- Colonna, P. C., *Regional Orthopaedic Surgery*, W. B. Saunders Co., Philadelphia, 1956.
- Dickson, J. A., *Jour. B. & J. Surg.*, 25, 1005, 1947.
- Magnuson, P. B., *A.M.A.*, 98, 1791, May 21, 1932.
- McMurray — See McFarland, Bryan, *Jour. B. & J. Surg.*, 36A, 476, 1954.
- Santos, J. V., *Arch. Surg.*, 21, 470, 1930.
- Whitman, R., *Am. J. Surg.*, 4, 169, 1929.
- Whitman, R., *N. Y. Med. Jour.*, February 7, 1891.

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# The RHODE ISLAND MEDICAL JOURNAL

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## THE STATE WORKMEN'S COMPENSATION PROGRAM

IN THE PRE-ELECTION CAMPAIGN both major political parties announced in their platforms that they believe there should be a review of the state workmen's compensation laws. In January, Governor DeSesto announced that as the result of a "cabinet" meeting he had appointed a subcommittee of three state department directors to undertake an immediate and comprehensive review of the workmen's compensation law and its administration. Named as chairman of the subcommittee is the Director of Labor under whose direction the program to be studied is administered.

The promptness of the Governor in carrying out his political party's pledge is commendable. The major emphasis appears to center on a study of the feasibility of creating a state fund for the program, either as an exclusive fund or as one in competition with insurance companies.

Of far greater importance, at least from the viewpoint of the physicians of Rhode Island, is the wide application of certain phases of the present law, and the disregard of other provisions that provide effective controls. For one example, let us take the question of compensation for inguinal hernia. Doctors agree that indirect inguinal hernia arises, many times, from a structural defect which has existed from childhood. Nearly all individuals so afflicted would have developed hernias regardless of their type of work, or even if they had never worked at all. Nevertheless, in Rhode Island inguinal hernia seems always to be compensable, and insurance

carriers no longer contest the problem.

Certainly some effort could be made by the administrators of the program to determine if the hernia was of recent origin or appeared suddenly; if its appearance was accompanied by pain; if it immediately followed an injury arising out of and in the course of employment; or if it existed prior to the injury for which compensation is claimed.

Again, take the matter of low-back strain.

In 1953 the Rhode Island Medical Society, of its own volition, introduced legislation to improve the medical phases of the workmen's compensation law, and included a provision calling for a special report on back injuries. When the entire act was revised and enacted in 1954, this provision was incorporated at the insistence of the medical society. After nearly five years under the new statute the medical advisory committee is yet to be consulted on the special back injury report, and apparently no attempt has been made to fulfill the intent of this provision.

Recent rulings of the Workmen's Compensation Commission have made coronary artery disease compensable if there is an acute attack while the patient is working. Such decisions should not be made without the most complete and exhaustive medical testimony, for the precedent established as a general rule not only proves costly to industry, but more particularly to the workers. Rhode Island doctors who are trying to rehabilitate their cardiac patients find that industry will not employ these

*continued on next page*



workers because of the compensable risk involved. The same attitude applies to any other illness that may again become active, and it is now difficult for any person so affected who is over the age of fifty to get employment. Yet such persons are employable.

Periodic review and revision of the statutes is advisable. The medical profession, which plays a major role in the Workmen's Compensation Program, acting through its Industrial Health Committee, worked with the various study commissions in the past and submitted worthwhile amendments. When legislative action was not forthcoming, the Society itself introduced legislation in 1953 that called for the appointment of impartial medical examiners, prompt filing of reports, the appointment of a full-time medical adviser, the establishment of a medical advisory panel to advise the medical director on the medical aspects of any case, the annual review of every case of total disability or severe permanent partial disability, and special reports concerning all back injuries.

Many of these provisions were incorporated in the revised statutes adopted by the General Assembly in 1954 when the Workmen's Compensation Commission setup was established.

Further amendments of the statutes may be warranted. However, we believe that more restrictive interpretation of the present law as regards its medical phases, the complete adoption of all provisions in the law, and a willingness to seek and accept competent medical advice and counsel from the appointed medical advisory committee, or beyond it, would be a greater contribution to the effectiveness of the program in the coming years.

### THE MURRAY S. DANFORTH ORATION

In November, 1958, the Second Murray S. Danforth Oration was delivered at the Rhode Island Hospital by Doctor Paul Colonna, *professor emeritus*, of orthopedic surgery, at the University of Pennsylvania. The oration is delivered annually as the highlight of the speaker's three-day tenure as surgeon-in-chief of the fracture and orthopedic departments of the hospital. The oration represents part of a broad program of resident and intern training in these departments. It was made possible by the munificence of Mrs. Danforth who endowed, in memory of her husband, the Murray S. Danforth Fund for teaching and research in orthopedics.

Doctor Colonna was graduated from the Johns Hopkins Medical School. For several years he worked in New York City before going to the University of Oklahoma, where he remained as professor of orthopedic surgery until 1942, when he accepted a similar position at the University of Pennsylvania. He is past president of the American Orthopedic Association.

Following his oration, Doctor Colonna presented a film illustrating the trochanteric reconstruction described in the oration, and showing several patients, before and after operation. Although originated by him, and known generally as the Colonna operation, such is the characteristic modesty of this distinguished teacher, that nowhere in the oration does he speak of the operation as his own.

### CANCER CONFERENCE — MARCH 18, 1959

In 1956, a panel on the management of patients with advanced cancer, was presented for Rhode Island physicians, by the Society's Cancer Committee. Another conference will be offered this year. A group of distinguished physicians from the Roswell Park Memorial Institute in Buffalo, New York, has accepted the invitation to give lectures at the Medical Library on Wednesday, March 18. The lectures will begin at two o'clock, and the four presentations will be completed in a three-hour period. This kind of postgraduate education is distinctly worth while for every physician. Assuredly, it is advantageous for Rhode Island doctors to be spared the time and expense of traveling to distant parts to learn of the most recent studies in the control of such an important disease as cancer. It is hoped that the Medical Library will be filled to capacity on March 18.

Lectures are to be on the following topics: Radiotherapy in Cancer; Some Aspects of Neoplasms of the Genital Tract; Cancer Chemotherapy; Immunological Aspects of Cancer; Cancer of the Gastrointestinal Tract.

The Roswell Park Memorial Institute is a state-supported hospital devoted to cancer therapy and research. It has a bed capacity of 300, and approximately 180 full-time staff members, including many outstanding scientists.

The Society's committee is to be congratulated on their success in securing the outstanding members of this hospital staff to journey to Providence to present what promises to be one of the most notable educational conferences in the long series which the Rhode Island Medical Society has sponsored through the years.

### WHAT ARE THEY CHEERING ?

According to Mr. Nims, director of the State Tax Bureau the 3% sales tax collected in November was \$25,000,000.00.

The newspapers of Thursday, December 25th reported a State of Michigan deficit of \$100,000,000.00.

At the beginning of the first world war the national debt was \$1,000,000,000.00.

At the end of the first world war the national debt was \$13,000,000,000.00.



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**MEDICAL BUREAU**  
of the  
**Providence Medical Association**

## WHAT ARE THEY CHEERING?

*concluded from page 106*

At the beginning of the second world war the budget of New York City equaled the total national budget of Japan excluding the Japanese military expense.

President Eisenhower in the State of the Union message predicted a balanced budget this year of \$77,000,000,000.00 with 60% of it for military expenditures.

Our national debt is in round figures \$275,000,-000,000.00. It's like skipping along the Milky Way from end to end and measuring it in light years: a few billion dollars more or less means little.

A certain type of bomber the President said "costs its weight in gold."

To put a single big intercontinental missile in the field costs \$35,000,000.00.

The State of Michigan is broke.

We are told that the Detroit city government is broke.

At the Detroit Club, Mikoyan, No. 2 man of the Soviet Union, spoke for two hours. At the end of his speech and at the end of the question period Russell Barnes of the DETROIT NEWS said he was given a standing ovation by the audience. The audience, the leaders of Detroit Business.

With these facts there is this paradox.

The President explained his budget's 60% of \$77,000,000,000.00 for defense as due to the Russian military threat.

The men at the Detroit Club gave Mikoyan a standing ovation. These dominant men of industry, commerce and finance don't follow the Soviet Line.

What are they cheering?

... Editorial reprinted from the DETROIT MEDICAL NEWS of the Wayne County Medical Society, Jan. 26, 1959, Vol. L, No. 38

### ATHLETIC INJURY SYMPOSIUM PLANNED FOR PHYSICIANS

A two-day symposium on *The Prevention and Treatment of Athletic Injuries* will be held on Monday and Tuesday, August 17 and 18, under the joint sponsorship of the Department of Physical Education and the Health Service of the University of Rhode Island.

The symposium, the first of its kind to be held on a major scale in New England, is designed primarily for all team physicians, athletic trainers and coaches of colleges, universities and public, private and parochial secondary schools in the New England, New York and New Jersey areas.

Doctor A. A. Savastano, Providence Orthopedic Surgeon, will serve as chairman of the medical section. The program will be under the direction of Professor Fred D. Tootell, director of the Department of Physical Education for Men, and Doctor S. J. P. Turco, director of the Health Service at the University.

## CANCER CONFERENCE FOR RHODE ISLAND PHYSICIANS

Wednesday, March 18, 1959, at the Medical Library  
from 2:00 P.M. to 5:00 P.M.

*Presented by members of the staff of the  
Roswell Park Memorial Institute  
for Cancer Therapy and Research, at Buffalo, New York*

### RADIO THERAPY IN CANCER

JOHN PARSONS, M.D.

### SOME ASPECTS OF NEOPLASMS OF THE GENITAL TRACT

JOHN GRAHAM, M.D.

### CANCER CHEMOTHERAPY

JAMES HOLLAND, M.D.

### IMMUNOLOGICAL ASPECTS OF CANCER, AND CANCER OF THE GASTROINTESTINAL TRACT

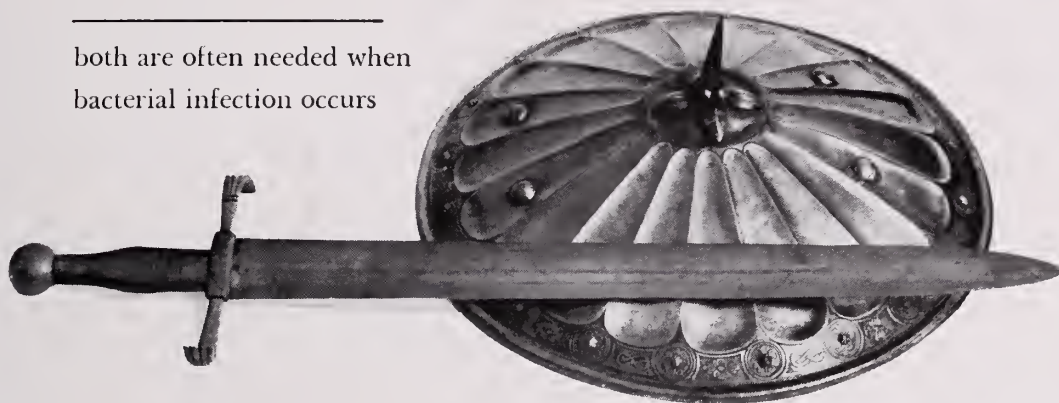
JAMES GRACE, M.D.

Sponsored by the Cancer Committee  
of the Rhode Island Medical Society



- prompt, aggressive antibiotic action
- a reliable defense against monilial complications

both are often needed when bacterial infection occurs



for a direct strike at infection

Mysteclin-V contains tetracycline phosphate complex

It provides a direct strike at all tetracycline-susceptible organisms (most pathogenic bacteria, certain rickettsias, certain large viruses, and *Endamoeba histolytica*).

It provides the new chemical form of the world's most widely prescribed broad spectrum antibiotic.

It provides unsurpassed initial blood levels — higher and faster than older forms of tetracycline — for the most rapid transport of the antibiotic to the site of infection.

for protection against monilial complications

Mysteclin-V contains Mycostatin

It provides the antifungal antibiotic, first tested and clinically confirmed by Squibb, with specific action against *Candida (Monilia) albicans*.

It acts to prevent the monilial overgrowth which frequently occurs whenever tetracycline or any other broad spectrum antibiotic is used.

It protects your patient against antibiotic-induced intestinal moniliasis and its complications, including vaginal and anogenital moniliasis, even potentially fatal systemic moniliasis.

# MYSTECLIN-V

Squibb Tetracycline Phosphate Complex (Sumycin) and Nystatin (Mycostatin)

Capsules (250 mg/250,000 u.), bottles of 16 and 100. Half-strength Capsules (125 mg/125,000 u.), bottles of 16 and 100. Suspension (125 mg/125,000 u. per 5 cc.) 60 cc. bottles. Pediatric Drops (100 mg/100,000 u. per cc.) 10 cc. dropper bottles.

SQUIBB



Squibb Quality — the Priceless Ingredient

\*MYSTECLIN®\*, \*SUMYCIN®\*, and \*MYCOSTATIN®\* ARE SQUIBB TRADEMARKS

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## PHYSICIANS SERVICE IN 1958

Report of the *President*, CHARLES J. ASHWORTH, M.D., to the Corporation  
of Rhode Island Medical Society Physicians Service, Tenth Annual Meeting,  
January 26, 1959

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THE EXPERIENCE of Physicians Service continued favorable through the year 1958. Enrollment increased by approximately 16,000 members, bringing the total number of subscribers from 505,000 to 521,000. Dollar-wise, the amount paid in claims increased by \$450,000 plus, or from \$5,796,851.00 to \$6,254,485.00. Just how uncomfortably narrow the margin was, however, is reflected in the net income added to reserves, \$149,-198.87. Operating cost is represented by 5.76%, still one of the lowest figures in the country.

The business and financial side of our plan is often the least understood aspect of its operation, yet nothing demands more expert direction and closer administrative attention. The need for emphasis in this area becomes clear when one realizes that a paramount obligation demands the maintenance of a sound balance between claims paid doctors, plus benefits rendered subscribers against premium income and basic operational costs.

Your treasurer's report confirms the fact that Physicians Service has continued to contain itself financially within the limits of premium income, while at the same time adding the benefits exceeding many comparable plans, yet wisely allocating annually something toward a necessary reserve. Full coverage for the mentally ill in the same category with other medical diseases is an example.

In the financial area as well as in the field of medical care, a modern progressive plan cannot be static. Its motion must be either forward or backward. Surely, Physicians Service is forward and, by the momentum of its past and present success, we hope will so continue.

It has been pointed out on a previous occasion that the evolution of a voluntary medical care plan is not without self-interest and sacrifice, hope and disappointment, and severe stress and strain, but ultimately achieving resolution in discussion and agreement. The greatest impetus to any progressive idea lies in the state of dissatisfaction it generates, not only in its novelty, but with the state of things as they are. Nothing of enduring merit ever evolves from timidity or conformance, and the prodigious and time-consuming efforts of each and all of you, throughout this past year, in your task of shaping an improved and better plan, bears ample

testimony to this fact. The light that has been generated by those many meetings has far exceeded any heat the discussions provoked, and most certainly has been productive of a broader and more enlightened understanding of the problem by an ever increasing segment of our profession.

The occasion of this tenth annual meeting could well devote some time in retrospection, but the importance of any detailed review of this decade of progress for Physicians Service is actually inconsequential by comparison with a brief but highly speculative glance at the immediate future. The annual analyses of prepaid medical care plans is now bringing into sharper focus the difficulties people have in paying for this type of protection, and also the problems that face us in increasing the effectiveness of voluntary health insurance.

No one is more aware of the truism than the physician that, to do better, one must know more and more about what one is doing. Recent years have been a real challenge to the practicing doctor to keep abreast of medicine's scientific progress; similarly, medical economics has imposed a corresponding obligation to be well informed about the growth and development of prepaid medical care as it is now available. Current knowledge about the personal medical bill of an average American citizen, and its relationship to health insurance, is a must. These two areas of information are inseparable. The cost of health insurance is directly related to the incidence of medical care, or usability, as well as a plan's operational efficiency. The development of out-patient hospital, convalescent, and nursing home facilities propose new areas of coverage, and at an unknown cost.

Have we, at this time, any concept of the limit to which benefits of health insurance can be extended? Perhaps a categorical NO would be a safe, if not a completely correct answer, but it should be recognized that we are faced with one immediate aspect of this extension, namely, our over-65 citizens.

You must share my desire to develop, along with many other similar plans in the country, a mechanism by which all physicians will be able to offer coverage to the indigents of this group at a cost commensurate with their ability to pay. If it can be

done with co-operative effort, it should take precedence over any other project we are now contemplating.

The present economics of financing medical care through prepayment presents a twofold problem. First, the public view of health insurance and the method of financing. Second, public satisfaction with present benefits and the extension of benefits that can be developed.

If the medical profession is intent upon retaining initiative in matters relating to people's health and health insurance through prepayment, then I cannot escape the obligation, much less fail of this opportunity, to suggest that we, as a profession, must rise unitedly above the worn-out retreats of stereotype expressions, unrealistic negativism, and indefensible defiance of an altering social environment that this changing era has thrust upon us. Experienced inquirers have concluded, after soul-searching scrutiny of the problem, that this complicated structure of integration with third parties and new patient relationships projects the future of medical practice in a different perspective than we have ever known.

The destiny of our plan is in your hands, as have been its past achievements. This very evening will be decisive. It will forecast the intent of the medical profession locally, at least, to adjust to the cataclysmic effects of a changing era in the private practice of medicine.

Your directors of Physicians Service will continue unselfishly to support the fundamental policy of making available to our subscribers, all and any

new benefits which can be offered but only in relation to commensurate financial increments to the servicing doctors within the limits of disburseable funds which, you know, derive from premium income.

May I express my personal thanks to the members of the Corporation, our executive director, Stanley Saunders, his assistant, Edgar Clapp, and their entire administrative staff for a year of tireless effort in assisting us to develop a new contract consistent with the success and progress Physicians Service has enjoyed these recent years. An especial word of commendation, may I utter for our Board of Directors, particularly the nonmedical members who have been so generous with their time to help us carry on so well this year. To the committees of the Board as well as the committees of the Rhode Island Medical Society, under the present meritorious leadership of Doctor Sargent, go my personal thanks for support, without which this report of progress would not be possible.

In conclusion, may I remind you of the extraordinary effort your directors have made to solidify our public relations through the recent series of advertisements in the daily papers of the state. While no accurate measurable standard of the success of this project is yet available, all indications to date point emphatically to wide approval and acceptance of our messages. To borrow a line from one of those recent appeals for better health care for more people through Physicians Service . . .

"If there were no Physicians Service, then what?"

If they need nutritional support . . .



they deserve

# GEVRAL<sup>®</sup>

Vitamin-Mineral Supplement Lederle

**CAPSULES—14 VITAMINS—11 MINERALS**

LEDERLE LABORATORIES, a Division of  
AMERICAN CYANAMID COMPANY, Pearl River, New York





# VARIDASE<sup>®</sup> BUCCAL TABLETS

Streptokinase-Streptodornase Lederle

Controls Inflammation and Swelling...Relieves Pain...  
Promotes Healing Through Enhancement of  
Fibrinolysis at the Site of Trauma or Infection.

**References:** 1. Innerfield, I.; Shub, H., and Boyd, L. J.: New England J. Med. 258: 1069 (May 24) 1958. 2. Miller, J. M.; Godfrey, G. C.; Ginsberg, M. J., and Papastrat, C. J.: J. A. M. A. 166:478 (Feb. 1) 1958. 3. Davidson, E.; Prigot, A., and Maynard, A. de L.: Harlem Hosp. Bull. 11: 1 (June) 1958 \*Reg. U. S. Pat. Off.

## In Sinusitis

Helps promote drainage...  
hastens patient's relief...  
reduces mucosal swelling.<sup>1</sup>

## Forcible Injuries

Contusions,  
and abrasions...  
reduces discomfort  
and improves  
cosmetic result.<sup>1-3</sup>

## Sprains, Fractures

Helps reduce swelling  
and pain...speeds  
ambulation.<sup>1-3</sup>



# TO ACCELERATE THE RECOVERY PROCESS

**Established Efficacy and Safety:** For five years VARIDASE, in parenteral form, has been used with success in many thousands of cases. Its ability to control inflammation, swelling and associated pain, aid penetration of antibiotics, and hasten healing has been demonstrated in such conditions as severe trauma, infected ulcerations, and following extensive surgery.

**Now, Parenteral Effectiveness . . . Simple Buccal Route:** New VARIDASE Buccal Tablets give your patients the benefits of systemic VARIDASE therapy without the inconvenience of repeated injections. Absorbed through the buccal mucosa in fully effective amounts, VARIDASE Buccal Tablets may be used as practical adjunctive therapy in your practice within these broad classifications:

Inflammation and edema associated with: trauma and infection • cellulitis • abscess • hematoma • thrombophlebitis • sinusitis • uveitis • chronic bronchitis • leg ulcer • chronic bronchiectasis.

Each VARIDASE Buccal Tablet contains 10,000 Units Streptokinase and 2,500 Units Streptodornase.

**Administration:** VARIDASE Buccal Tablets should be retained in the buccal pouch until dissolved. For maximum absorption patient should delay swallowing saliva.

**Dosage:** One tablet four times daily for a minimum of three days. When infection is present, VARIDASE Buccal Tablets should be given in conjunction with an antibiotic such as ACHROMYCIN\* V Tetracycline and Citric Acid.

Available in bottles of 24.

\*Reg. U. S. Pat. Off.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



**Chronic Bronchitis**

Loosens cough...resolves inflammation... increases antibiotic penetration.<sup>1</sup>

**Thrombophlebitis**

Relieves thrombotic process, controls swelling...gives dramatic relief of pain.<sup>1, 2</sup>

**Skin Infections**

Furuncles, carbuncles, abscesses...checks swelling and pain...hastens healing.<sup>1, 2</sup>

**Watch it work in your practice!**



## DISTRICT MEDICAL SOCIETY MEETING

### PROVIDENCE MEDICAL ASSOCIATION

The 112th Annual Meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, January 5, 1959. The meeting was called to order by Doctor Joseph G. McWilliams, president, at 8:30 P.M.

Doctor McWilliams stated that the minutes of the previous meeting would be published in the RHODE ISLAND MEDICAL JOURNAL and that there would be no reading of them at the meeting unless there was a request.

#### *Annual Report of the Secretary*

Doctor Michael DiMaio, secretary, read his annual report, copy of which is made part of the official minutes of the meeting. The report was received and placed on file.



JOHN C. HAM, M.D.

President, 1959

The Providence Medical Association

#### *Annual Report of the Treasurer*

Doctor Frank I. Matteo, treasurer, read his annual report which was received and placed on file.

#### *Presidential Address*

Doctor Joseph G. McWilliams delivered his presidential address in which he reviewed the development of the Medical Bureau of the Association, and cited its outstanding service to the physicians and to the public in the greater Providence area.

#### *Election of Officers*

The secretary reported that no counter nominations had been received to the slate of officers nominated by the Executive Committee and submitted to the members early in December. He, therefore, moved the election of the slate of officers and delegates for 1959 as submitted by the Executive Committee, as follows:

#### *Officers for 1959*

<i>President</i>	JOHN C. HAM, M.D.
<i>Vice President</i>	IRVING A. BECK, M.D.
<i>Secretary</i>	MICHAEL DiMAIO, M.D.
<i>Treasurer</i>	FRANK I. MATTEO, M.D.
<i>Trustee of Medical Library (1 year)</i>	FRANCESCO RONCHESE, M.D.
<i>Councillor to R. I. Medical Society</i>	JOSEPH G. McWILLIAMS, M.D.
<i>Executive Committee (3-year terms)</i>	BERTRAM H. BUXTON, JR., M.D.
	FRANK D. FRATANUONO, M.D.
	JOSEPH G. McWILLIAMS, M.D.
	RALPH D. RICHARDSON, M.D.

*Delegates to the House of Delegates of the Rhode Island Medical Society:* Robert R. Baldrige, M.D.; Irving A. Beck, M.D.; J. Robert Bowen, M.D.; Alex M. Burgess, Jr., M.D.; Bertram H. Buxton, Jr., M.D.; Wilfred I. Carney, M.D.; Francis H. Chafee, M.D.; Harry E. Darrah, M.D.; Michael DiMaio, M.D.; William J. H. Fischer, Jr., M.D.; Henry B. Fletcher, M.D.; Frank Fratanuono, M.D.; J. Merrill Gibson, M.D.; John F. W. Gilman, M.D.; Seebert J. Goldowsky, M.D.; Stanley Grzebien, M.D.; John C. Ham, M.D.; Joseph Hindle, M.D.; Walter S. Jones, M.D.; Ernest K. Landsteiner, M.D.; Frank C. MacCardell, M.D.; Joseph G. McWilliams, M.D.; William S. Nerone, M.D.; Francis W. Nevitt, M.D.

concluded on page 116





For 100 years, rain or shine, through peace and war, the world-famous Big Ben has faithfully proclaimed the hour to citizens of London

## THINGS THAT ENDURE

Good things endure... a work of art, a literary classic, a proud bridge... a dependable pharmaceutical. Such is **Desitin Ointment**. For over 35 years Desitin Ointment has endured as an incomparable, safe way to prevent and clear up diaper rash...and as a soothing, healing application in wounds, burns, external ulcers and other skin injuries.

Desitin®

DESITIN CHEMICAL COMPANY Providence 4, R. I.

## PROVIDENCE MEDICAL ASSOCIATION

*concluded from page 114*

Arnold Porter, M.D.; William A. Reid, M.D.; Ralph D. Richardson, M.D.; Carl S. Sawyer, M.D.; William J. Schwab, M.D.; James J. Sheridan, M.D., and Stanley D. Simon, M.D.

The motion was seconded and unanimously adopted.

*Induction of New President*

Doctor McWilliams named Doctors Alfred L. Potter and Robert R. Baldrige, past presidents of the Association, to escort Doctor John C. Ham, the new president, to the rostrum. Doctor Ham briefly thanked the members for the honor given him and expressed his hope that he would have the complete co-operation of everyone in carrying forward the work of the Association during 1959. At the conclusion of his remarks, he presented an inscribed gavel to Doctor McWilliams for the Association.

In accepting the gavel, Doctor McWilliams noted that through the years the procedure had been to present the outgoing president with an engraved gavel, but this year the Executive Committee had voted that the incoming president be given his gavel at the first meeting; and, therefore, for the Association he presented to Doctor Ham his gavel signifying his authority as leader of the Providence Medical Association.

**IMPORTANT ANNOUNCEMENT**

AFTER MANY MONTHS OF CAREFUL  
STUDY YOUR RHODE ISLAND MEDICAL  
SOCIETY COMMITTEE ON INSURANCE  
HAS APPROVED AN EXCELLENT  
NEW PROGRAM OF . . .

**CATASTROPHIC**

Hospital — Nurse Expense Insurance  
and

**OVERHEAD EXPENSE REIMBURSEMENT**

\* \* \*

**LOOK FOR THE DETAILS**

in your mail this month

This plan is considered to be most advantageous to members. Be sure to give it serious consideration!

**R. A. Derosier Agency**

32 Custom House Street  
Providence 3, Rhode Island

**GAspee 1-1391***Committee Reports*

The president noted that committee reports would be published in the RHODE ISLAND MEDICAL JOURNAL but any chairman wishing to make a recommendation to the members could do so during the meeting. There were no recommendations made.

*Applicants for Membership*

Doctor DiMaio reported that the Executive Committee recommended for election to active membership Doctor George W. Anderson, of the Providence Lying-In Hospital. The motion was seconded and adopted.

*Awarding of Membership Certificates*

Doctor McWilliams awarded membership certificates to the members elected at the December meeting of the Association, and also to Doctor Anderson.

*Scientific Lectures*

The president introduced as the guest speaker Doctor James A. Watt, Director, National Heart Institute, The National Institutes of Health, Bethesda, Maryland. The doctor spoke on the subject *The Pharmacological Revolution*.

Doctor Watt reviewed the use of drugs for specific diseases. Until recently, he noted, these amounted to a very insignificant number. He mentioned morphine—a specific for pain, and quinine—a specific for malaria. The development of the chemotherapeutic agents—the sulfonamides, and the antibiotics—penicillin, streptomycin, tetracycline, etc., opened up new and vast avenues for research and treatment.

A major pharmacological revolution is now in progress in an attempt to solve cancer therapy. The speaker said that 30,000 to 50,000 compounds are being screened annually in cancer research. He predicted that *not one* but a *number* of compounds will be necessary to eradicate cancer.

An active discussion followed Doctor Watt's paper.

*Adjournment*

The meeting was adjourned at 10:10 P.M.  
Attendance was 74.

Collation was served.

Respectively submitted,

MICHAEL DiMAIO, M.D., *Secretary*

**Cancer Conference for Physicians**

at the Medical Library

**Wednesday, March 18, at 2:00 P.M.**

# PROFESSIONAL SERVICE FOR PROFESSIONAL MEN



## Industrial National's *Convertible* Living Trust

If you manage your own investments, you'll be interested in Industrial's *Convertible* Living Trust. This professional investment service can assist you in several vitally important ways.

- Takes care of the "paperwork" of investment activity, including the chores of record keeping; simplifies the preparation of various tax returns, and frees you from many other administrative duties.

- Protects you against the possibility of suffering severe financial losses if the press of other business, travel or illness causes you to be temporarily or permanently unable to handle your own investments.

- Assures maximum protection for your investments in the event that ultimate beneficiaries, members of your family, may be lacking in investment experience and ability.

Our *Convertible* Living Trust provides an extremely flexible property arrangement under which you and your beneficiaries receive financial services that conform to your actual needs and circumstances. For full information, with no obligation involved, write to our Trust Department, Box 1466, Providence, or call Jackson 1-9700, extension 534.



TRUST DEPARTMENT

# Industrial NATIONAL BANK

Member Federal Reserve System    Member Federal Deposit Insurance Corporation



## MILK COMMISSION REPORT — PROVIDENCE MEDICAL ASSOCIATION, 1958

CERTIFIED MILK in Providence during 1958 was obtained from the following farms: Cherry Hill Farm, North Beverly, Mass.; Hampshire Hills Farm, Wilton, N. H.; Hillside Farm, Cranston, R. I.

Through the courtesy and co-operation of the Boston Commission we have accepted their certification of one farm from Massachusetts and one from New Hampshire.

All of the herds are under State and Federal supervision and are free from Tuberculosis and *Brucella abortus* infections.

The Commission, five years ago, discontinued the sale of Raw Certified Milk in the Providence market to conform with the standards in most of the larger cities. The legal standard for Pasteurized Certified milk is still 500 colonies per ml. and the actual count on all samples examined by this Commission the past year was 39 colonies per ml.

Vitamin D Certified Milk is defined as whole Certified Milk rendered antirachitic by irradiation or by the addition of a concentrate and shall be of sufficient vitamin potency to show, by biological assay, a content of at least 400 U.S.P. units per quart.

The Wisconsin Alumni Research Foundation of Madison, Wisconsin, is doing the assaying of Vitamin D from Hillside Farm and the results have been entirely satisfactory. Two tests per year are required by this Commission.

Certified Fat-free (Skim) Milk, containing not more than 0.05 per cent butter fat, and with Vitamin A added has conformed to the standards set by the American Association of Medical Milk Commissions.

During the past year the Ring Test was performed once per month on Certified Milk and all tests were negative. This is the test acceptable to this Commission for determination of the presence of *Brucella Agglutinins*.

Out of about 600 samples of Certified Milk we have only found three (3) samples which had a Coliform colony count above 10 per ml.

During the past year the analysis of milk samples has been performed in the laboratories of the Rhode Island Quality Milk Association, a nonprofit organization established to promote the improvement and maintenance of the standards of milk, cream and milk products. The Board of Directors of this group is selected from consumers, producers, distributors and Public Health officials. The Rhode Island Medical Society is represented by one member on the board.

Two samples of Certified Milk from each dealer are examined twice weekly and more often if found necessary.

The Sanitary Inspector is appointed by the Commission to supervise the sanitary conditions at the farm and the physician is responsible for the health of the employees at the farm. Both of the men are licensed practitioners. The Veterinarian to the farm is also appointed by the Commission.

JOHN T. BARRETT, M.D., *Chairman*

REUBEN C. BATES, M.D., *Secretary*

BERTRAM H. BUXTON, JR., M.D.

HAROLD G. CALDER, M.D.

JOHN E. FARLEY, M.D.

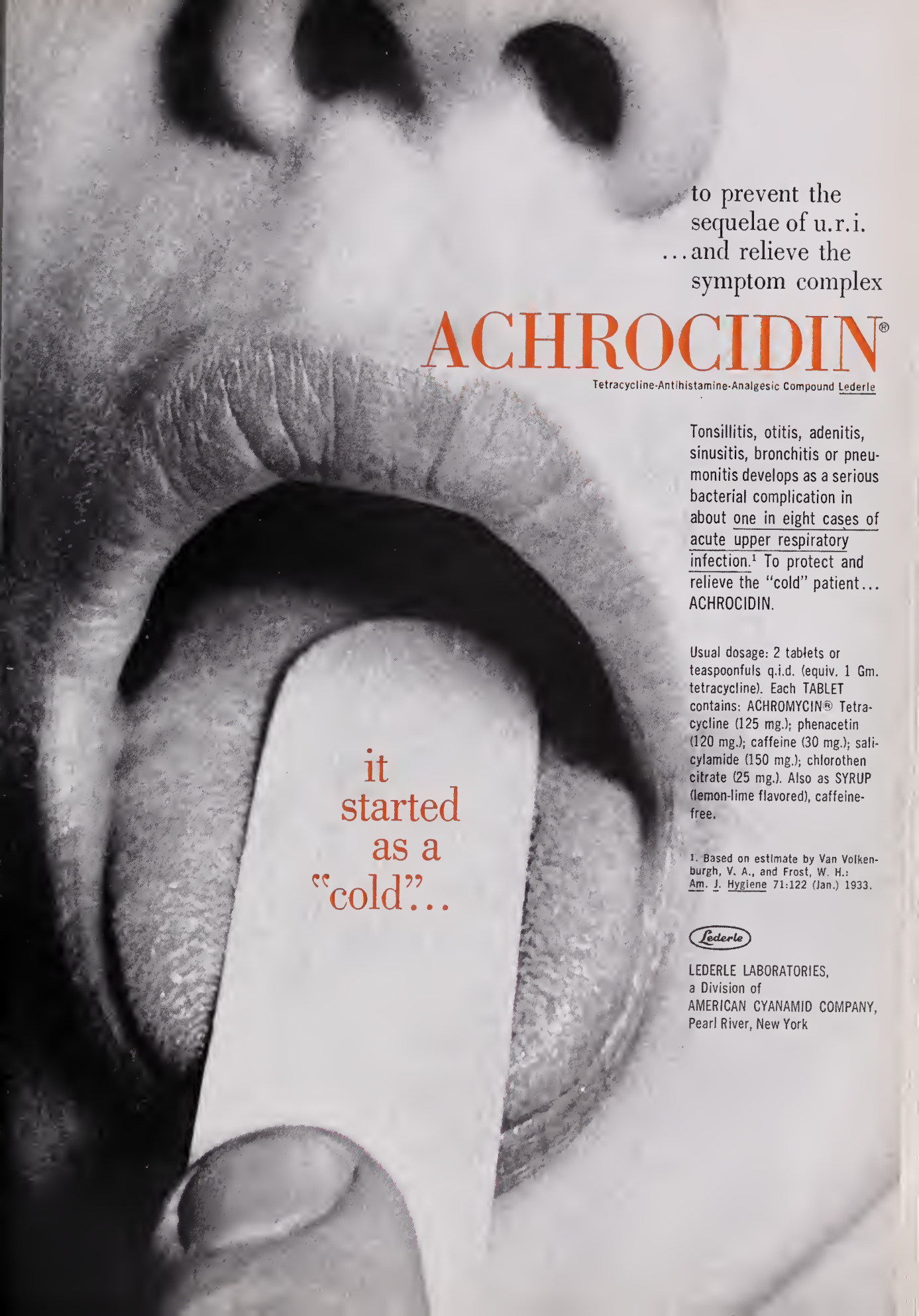
JOHN P. GRADY, M.D.

MAURICE KAY, M.D.

HENRY E. UTTER, M.D.

## MONTHLY AVERAGES OF CERTIFIED MILK FOR 1958

	CHERRY HILL H. P. HOOD			HAMPSHIRE HILLS			HILL-SIDE FARM					
	Pasteurized			Pasteurized			Pasteurized			Skimmed with Vit. A & D		
	B.F.	T.S.	Bac- teria per C.C.	B.F.	T.S.	Bac- teria per C.C.	B.F.	T.S.	Bac- teria per C.C.	B.F.	T.S.	Bac- teria per C.C.
January	4.0	12.81	14	4.8	14.39	18	3.9	12.49	7	.06	8.66	9
February	4.1	12.93	19	4.3	13.56	166	3.9	12.46	15	.04	8.79	7
March ..	4.0	12.83	15	4.4	13.75	18	3.9	12.50	8	.04	8.79	6
April	4.0	12.79	14	4.0	12.91	75	4.2	12.79	10	.04	8.98	8
May	3.9	12.70	10	4.1	13.20	40	4.0	12.49	127	.03	8.90	9
June	4.0	12.76	24	4.1	12.90	119	4.0	12.55	83	.05	8.74	10
July	4.1	12.81	75	4.0	13.01	31	3.6	11.88	17	.02	8.54	17
August	4.0	12.75	14	4.2	13.31	57	4.1	12.38	29	.03	8.61	17
September	4.0	12.46	17	4.4	13.42	88	4.2	12.71	15	.05	8.69	22
October ..	4.0	12.93	35	4.3	13.55	44	4.2	12.70	12	.04	8.75	19
November	4.1	13.00	17	4.2	13.51	39	4.1	12.48	282	.03	8.63	22
December	4.0	13.06	6	4.6	13.62	5	4.0	12.41	162	.04	8.55	18
Yearly Average	4.0	12.81	22	4.3	13.42	58	4.0	12.48	64	.04	8.71	13



to prevent the  
sequelae of u.r.i.  
...and relieve the  
symptom complex

# ACHROCIDIN<sup>®</sup>

Tetracycline-Antihistamine-Analgesic Compound Lederle

Tonsillitis, otitis, adenitis, sinusitis, bronchitis or pneumonia develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.<sup>1</sup> To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN<sup>®</sup> Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

it  
started  
as a  
"cold"...

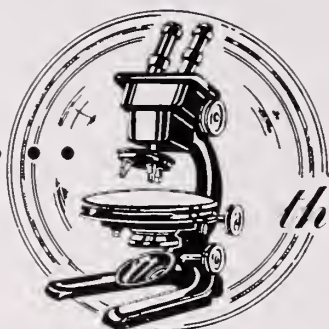
1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933.



LEDERLE LABORATORIES,  
a Division of  
AMERICAN CYANAMID COMPANY,  
Pearl River, New York



THROUGH .

*the Microscope*

### *Medical Care Spending Studied*

In a recent issue of *PROGRESS IN HEALTH SERVICES*, the Health Information Foundation pointed out that spending for hospital care, physicians' services, and other health items last year took 5.3 per cent of the public's consumer-expenditure dollar—a 40 per cent increase over the 1929 figure of 3.7 per cent.

For this stepped-up outlay, however, Americans are receiving a greater quantity and variety of services, as well as vastly improved quality.

"In the past," said the Foundation, "pain, disability, and serious illness could be faced at relatively little expense—simply because there was relatively little that could be done for a sick person. Now pain and disability can often be avoided and death greatly postponed—but at the cost of more visits to physicians, more admission to hospitals, more use of drugs and other treatments."

The H.I.F. report singled out four trends that have contributed to the high quality of modern medical care, but at added cost to the consumers:

The average annual number of patient days in general and special hospitals in the United States rose from 0.88 in 1935 to 1.25 in 1956.

During that time the number of births in hospitals increased from just under 800,000 to about 3.8 million a year.

In 1928-31 an annual average of 2.6 out-of-hospital doctor visits was reported by white persons in this country, against a figure of 4.8 in 1957 for the entire population.

During the same period, the proportion of persons seeing a physician at least once a year climbed from 48 to 63 per cent.

For these and other reasons, private spending for medical care is today at an all-time high. The total outlay last year (not counting government, philanthropic and business expenditures) came to about 15 billion dollars, five times the total for 1929.

During that time, the Foundation reported, per capita spending for medical care also increased greatly, from about \$24 to \$89. Even when per capita figures are expressed in constant dollars, medical spending has almost doubled—from about \$33 to \$65—since 1929.

Some components of medical spending have risen faster than others. Hospital care, which claimed only 13.7 per cent of the consumer health dollar in 1929, last year accounted for a larger share than any other item—25.8 per cent.

Expenditures for physicians' services—which claimed 32.5 per cent of the medical dollar in 1929—took only 24.5 per cent in 1957. The proportion paid for dentists' services also declined, from 16.4 to 11.3 per cent.

Medical care, said the Foundation, "is now becoming a more important part of the American standard of living, while as an 'industry' it is becoming a more important part of the American economy."

George Bugbee, Foundation president, added that "recent increases in spending for medical care do not seem excessive." In fact, he said "many authorities believe that we do not yet spend enough for health items.

"In particular, more could be done to ward off illnesses through such preventive measures as regular physical checkups and immunizations."

### *American Philanthropy Sets New Record*

Eighty-two gifts and bequests each of a million dollars or more and totaling over a half billion dollars were made to American philanthropy in 1958, it was revealed recently in the *BULLETIN OF THE AMERICAN ASSOCIATION OF FUND-RAISING COUNSEL, INC.*

The AAFRC compilation of "Big Gifts" cited a total of 544,840,902 dollars in 1958 of which 346,525,253 dollars, or 46 per cent was made in bequests; 60,458,000 dollars given by 23 living do-

*continued on page 124*





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(with a natural human metabolite)

**Proven in practice**

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In most simple edema, one DIAMOX daily produces ample diuresis . . . safely—nontoxic and nonirritating to renal or gastric areas; no notable changes in blood pressure or electrolyte balance. Because DIAMOX is rapidly excreted, dosage is easily adjusted and does not interfere with sleep.

**cardiac edema • premenstrual tension • edema of pregnancy • obesity**



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**DIAMOX**

the  $\text{HCO}_3^-$  regulating diuretic

**2**

**DOUBLE  
DRUG CONTROL  
OF INTENSIVE  
DIURESIS**

Alternating DIAMOX with chloride-transport regulating diuretics achieves more dynamic diuresis than with either alone. By counterbalancing the tendency of these agents to produce systemic alkalosis, DIAMOX helps potentiate the diuretic effect, lessen risk of acquired tolerance and prolong intensive diuresis.

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Although mode of action has not been exactly defined in either instance, clinical experience has repeatedly proved DIAMOX a safe, efficient means of reducing intraocular pressure in glaucoma and controlling seizures in both young and adult epileptics.



## THROUGH THE MICROSCOPE

*continued from page 120*

nors, 13,279,000 dollars given by seven corporations, and 124,578,649 dollars by 42 foundations.

The compilation also showed that health and welfare received the greater proportion of the bequests, while education received the bulk of gifts made by living donors. Of the total, 296,263,781 dollars went to health and welfare causes, 159,802,121 dollars to education, 16,275,000 dollars to religious causes and 72,500,000 dollars to the fine arts.

As previously revealed by the Association, American philanthropy set a new record in 1958 with total contributions conservatively estimated at 7.1 billion dollars compared with \$6.7 in 1957. Over-all contributions of individuals accounted for 5.6 billion dollars and corporate contributions are estimated to have reached 525 million dollars of the 1958 total.

The American Association of Fund-Raising Counsel is an organization of 27 firms which specialize in counseling on and management of fund campaigns for philanthropic organizations. Its membership covers the United States and Canada.

*Health Insurance for the Aged*

Of an estimated 15 million Americans 65 and over, Health Information Foundation reports, 39 per cent now carry some form of voluntary health insurance. The aged population is expected to reach 25 million by 1980.

The proportion of persons 65 and over with some form of voluntary health insurance increased by about half from 1952 to 1957, according to Health Information Foundation. In 1952 only 26 per cent of the aged were insured against the costs of hospital and/or medical expenses; by 1957 the proportion had risen to almost 39 per cent.

About three fifths of the aged population (65 and over) in this country are not insured against hospital and/or medical expenses. Among the uninsured, Health Information Foundation states, more than one-fourth have never tried to buy health insurance, and almost as many say they don't want it. Thirty-four per cent of the uninsured say they can't afford it, while 16 per cent say they do not believe they are eligible for it.

Thirty-nine per cent of the persons 65 and over in this country now have some type of voluntary health insurance. Of these, at least 93 per cent have hospitalization insurance, while 67 per cent are protected against in-hospital doctor bills and 21 per cent against physicians' charges outside the hospital.

*Top-Level Committee Urged to Advise Congress on Medical Research*

The head of one of the nation's largest pharmaceutical firms recently called for the establishment of a permanent, top-level committee to advise Congress and Federal agencies on medical research.

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† warts; moles; sebaceous cysts; benign tumors; wounds; lacerations; biopsies; tying superficial varicose veins; minor rectal surgery; simple fractures; compound digital injuries (not involving tendons, nerves or bones)



Francis Boyer, chairman of the Board of Smith Kline & French Laboratories, told the American Association for the Advancement of Science that the need for such a committee is "imperative" in view of the rapid expansion of Federal allocations for medical research. Boyer pointed out that in 1940, the U. S. government spent only 3 million dollars on medical research, but that last year the figure was 186 million dollars, with expectations that by 1970 the sum will reach 500 million dollars.

"It is scarcely worth laboring the point that the impact of federal expenditures upon medical research . . . has already been tremendous and inevitably will become almost 'thermonuclear,'" said Boyer. "There is to my mind an imperative need for an independent and, above all, a permanent group of consultants which will serve as a source of top-level advice and support to the Surgeon General, to the Secretary of Health, Education and Welfare, and to Congress itself."

Boyer said one of the committee's most important contributions would be educational—by informing the U. S. on the facts of medical research and by publicly backing the medical research programs of the government.

#### *1958: A Record Year—1,133,654 Dollars for Medical Education*

The million plus dollars received by the American Medical Education Foundation noted above established new records, both in amount and numbers of

contributors. The 15% jump in income over 1957's total of \$984,884 is certain to be matched by an equally large increase in the number of givers, although the final count of contributors is not, as yet, available.

The month of December also establishes a record for a thirty-day period with over \$540,000 being received. The AMEF headquarters staff received compliments for its work in processing each of the 6,500 checks received during the month.

Outstanding efforts by many states and general increases in nearly all areas account for the large increase of the 1957 figures. In a news article prepared for wide distribution, A.M.A. president Dr. Gunnar Gundersen calls the result, "... evidence of organized medicine's increasing concern over the financial plight of its schools." In a special issue of *THE FOUNDATION* a complete listing of comparative totals by states will be given.

The distribution of grants to the medical schools will be made at a special ceremony during the Congress on Medical Education and Licensure on February 9.

#### *National Cancer Institute Reports on Mitomycin C*

The Cancer Chemotherapy National Service Center reported January 22 that Mitomycin C, an antibiotic reported as giving promising results in cancer treatment in Japan, has frequently produced

*continued on page 128*

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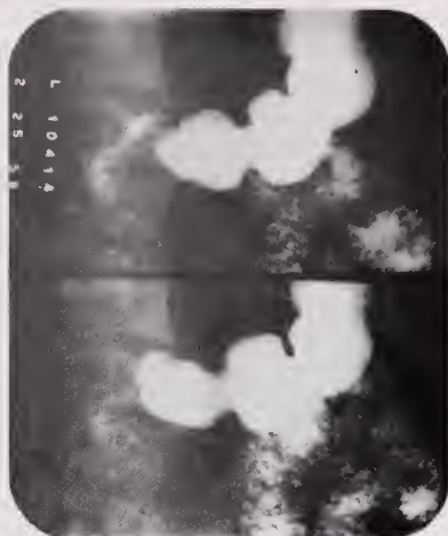




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*Patient A.S., age 53.*  
Intermittent crises of severe pain over 2 year period; hospital management with Sippy regimen provided relief of symptoms; however, symptoms recurred after each sojourn.



*PATHIBAMATE (Tabs. *q.t.i.d.* and H.S.);*  
prompt relief of symptoms. Radiograph  
(21 days later) confirms healing of minute lesser  
curvature gastric ulcer crater.

predictable results in the control  
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Bottles of 100 and 1,000. Each tablet (yellow, 1/2-scored) contains Meprobamate, 400 mg.; PATHILON Tridihexethyl Chloride, 25 mg.

**Administration and Dosage:**

1 tablet three times a day at mealtimes and 2 tablets at bedtime. Adjust dosage to patient response. Contraindicated in glaucoma, pyloric obstruction, and obstruction of the urinary bladder neck.

**Also Available:** PATHILON in four forms — Tablets of 25 mg., plain (pink) or with *phenobarbital*, 15 mg. (blue);

*Parenteral* — 10 mg./cc. — 1 cc. ampuls;

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\*PATHILON is now offered as tridihexethyl chloride instead of the iodide, an advantage permitting wider use, since the latter could interfere with the results of certain thyroid function tests.



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## THROUGH THE MICROSCOPE

*continued from page 125*

major toxic reactions but seldom objective improvement in clinical trials in the United States.

The antibiotic has been under pilot clinical evaluation in this country as an anti-tumor agent in a substantial variety of tumors. In view of the effects observed in three current studies, it has not so far replaced the standard chemotherapeutic agents in any form of cancer, the Chemotherapy Center's announcement said. Full reports on the clinical trials will appear later in the scientific literature. Meanwhile, studies of the drug are being continued.

Japanese experience in treating human cancer with Mitomycin C was reported at a symposium on antibiotics in Washington, D. C. October 16, 1958. A limited quantity for clinical trials in this country was produced by Bristol Laboratories for the Cancer Chemotherapy National Service Center.

***Public Apathy Cited as Cause  
For Paralytic Polio Rise in 1958***

An alarming recurrence of polio epidemics in 1958 resulting from a dangerous vaccination slowdown was cited recently by the president of The National Foundation (originally for Infantile Paralysis), as one of two major events in his review of the 1958 health activities of the March of Dimes organization.

Mr. Basil O'Connor asserted that 1958's 43 per cent rise in paralytic polio over 1957 was due in large part to "carelessness and apathy on the part of the American public." Only half as much vaccine was shipped out for domestic use in 1958 as in 1957, he said.

"Nearly four years after the Salk vaccine was officially declared a safe and effective preventive against polio paralysis," said Mr. O'Connor, "we have seen tragic breakthroughs of disease that need never have happened. The worst was in Detroit during the summer and fall of 1958, with lesser epidemics in Virginia, West Virginia, New Jersey and Hawaii."

Most of the 1958 epidemics, said Mr. O'Connor, occurred in low-income areas where relatively small portions of the population had any vaccine. In Detroit, for instance, the bulk of polio victims were from low-income families. In Wise County, Va., he pointed out, only 15 to 25 per cent of the inhabitants, mostly miners' families in a depressed area, had received any vaccination, and no children born since the distribution of free vaccine by The National Foundation in 1955 had been vaccinated in any of the southwestern Virginia mining counties.

"A house-to-house survey made by the U.S. Public Health Service's Communicable Disease Center in Atlanta," said Mr. O'Connor, "showed that polio vaccination status frequently reflected family in-

*concluded on page 129*

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## THROUGH THE MICROSCOPE

*concluded from page 128*

come levels—high vaccination figures for high-income groups, low vaccination figures for low-income groups. In other words, through surveys health authorities can spot many of the low vaccination areas, especially in urban centers; it is now essential to see that people in these areas get vaccinated."

## THE TELEPHONE THAT NEVER SLEEPS

*concluded from page 101*

the routine, without undue publicity. Maybe this excerpt from a letter from a patient aided by the Bureau will give you some idea of how people feel: "It is reassuring to know that someone is always on watch day and night, when real help is suddenly needed."

The fact that these operators have a pretty good sense of timing and use their own judgment is most important. Occasionally it is necessary for them to decide whether the doctor should be sent first, or the rescue squad or the police, or the ambulance; and sometimes their timing in this matter has made the difference between life and death. It is, I think, vital for all of us to know that this is our Bureau and to do as much as we can to make their work smoother. I asked Mrs. Beagan, when I was there, just what word she would like me to carry to you, and she said specifically that she would like, please, for the doctors to let the Bureau know where they are. She doesn't mean by this that you have to be on call all the time, necessarily, but at least let them know whether you *are* on call and, if so, where you are. I am sure that we, with a little bit of thought, can do this. I know that since I made my visit to the Bureau, I am more conscientious about notifying them when I leave the hospital, when I am going home, etc. All calls are filed and kept for a reasonable time. All have the time of receipt stamped on them by an electric timer and the disposition of each case.

This Medical Bureau, of which we are the masters so to speak, warrants the highest commendation not only from our Society but also from the public at large. We have never sought to publicize our good works here. Certainly we have been subject to some criticism in the past, but here, undoubtedly, is a work which warrants the highest regard of all the people who live in the area served by Jackson 1-2331—"the telephone that never sleeps."

**Cancer Conference for Physicians**

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**Wednesday, March 18, at 2:00 P.M.**

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## DOCTORS ON HOSPITAL BOARDS

A *PRO* and *CON* Presentation of the Subject reprinted  
from *NEW YORK MEDICINE*, the Official Journal  
of the Medical Society of the County of New York

The Author, *Doctor Philip D. Allen is chief of Surgery, Knickerbocker Hospital, New York, and the immediate past president of the Medical Society of the County of New York.*

*PRO*

WITHOUT having had the opportunity to see the accompanying article on why physicians ought NOT to be elected to the board of trustees of a nonprofit, voluntary community hospital, I believe a valid argument can be made that they should have some *voice* and *vote* within the inner circles of policy-making in such an institution.

1. I believe the pendulum has, in some areas, swung too far toward the concept that nonprofit hospitals are community institutions and thus all control shall be vested in the layman citizens of the community who serve on the board of trustees. That the pendulum should swing is understandable. In the beginning the first hospitals were founded and created by physicians and medical societies for no one else in the community had the vision to realize the need for hospitals. Like insane asylums and poorhouses, the first hospitals were often regarded by the laymen of a community as pest houses; a place to put the sick and infirm out of the way and screen them from the community. In a past day of the great epidemics of the plague, typhoid fever, typhus, smallpox, etc., this was understandable.

2. Because the medical profession created the first hospitals, a natural step in evolution was that the physicians should control the hospitals, which they did for many, many years. This led some physicians to the idea that a hospital is only a "workshop" for doctors who should be supreme in their hospital domain, guiding not only the medical and surgical services but setting policy also. There may be some few doctors who will even argue for this today, though it is an untenable position.

3. The natural and drastic reaction to this idea that a hospital is only a workshop for a physician was to remove all control of policy from the physicians on the staff and "put them in their place"—to allow them only final decision only on matters of medical and surgical services.

This is the stage of thinking in many hospitals today. In the swing of the pendulum in this broad

top-level policy picture, therefore, the physicians are sometimes regarded only on a level with the nursing staff, the building maintenance department, and the other housekeeping services, and ancillary diagnostic departments. To co-ordinate all the departments comes the hospital administrator—sometimes a physician, sometimes not—who reports to the trustees, as their eyes and ears, and, in turn, executes the policy decisions of the trustees.

4. When this stage arrives, the trustees become insulated and isolated from medical opinion and thought. Too often they take action in expanding hospital functions and services which have great and sometimes adverse impact upon the practice of medicine in a community. This is because, too often, they do not distinguish between physicians and think that the opinion of one physician (say the doctor-administrator) truly represents the thinking of the medical community as a whole or the medical staff within the hospital. This isolation from general medical thinking is the great weakness in the argument of those who say that physicians should not be elected to the board of trustees of a hospital. To thus argue is to say that only the lay citizens of the community—and not the physicians—are interested in, and should set policy, in matters of medicine.

5. I would argue that as the very minimum the physician who is chief of the medical board of the hospital should have voice and vote on the board of directors of the institution. If another physician on the staff, who is active in leadership in the local medical society, could be elected to the board of trustees, I believe that would be better. No one will argue that physicians should dominate the board but it is valid and vital that current medical thinking—both at the medical staff level and at the medical community level—should be available to the board of trustees and indeed, that this segment of the board medical interest have a voice and vote in the hospital's policy decisions.

6. On this last point, I would recommend that the physician members of the board hold their term of office not forever—as sometimes seems to be the case with hospital trustees—but only while they are active in their respective roles. When another physician becomes chairman of the medical board of the hospital he should replace his former counter-



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## DOCTORS ON HOSPITAL BOARDS

*concluded from page 132*

part. And when the physician of the staff who represents local medical thinking is no longer active in his medical society, he, too, should be replaced.

7. If these measures were undertaken I believe many frictions which now arise between hospitals and the medical community could be eliminated or at least minimized. The hospital trustees would have reliable information on which to make their decisions and the medical staff of the hospital and the medical community, as a whole, would better be aware of how the policy decisions were determined. Too often hospitals have the tendency to go their own independent way. Certainly the local medical society is also a responsible part of the community. Indeed, it held that role long before the idea of hospital trustees was ever conceived. To eliminate the medical profession from policy decisions by hospitals is unwise. Thus I argue that physicians should have voice and vote at the level of policy decision on the board of trustees.

---

*The Author. Mr. Lloyd Westcott is Chairman of the Board of Trustees of Hunterdon Medical Center, Flemington, New Jersey.*

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## CON

**S**HOULD DOCTORS be members of hospital boards of trustees? It has always astonished me to find how diverse, yet how firmly and heatedly held, are the opinions on this subject.

I am one of those who hold (as firmly and heatedly as anyone) the position that there should be no doctors on hospital boards. Before you discard this article in a rage let me try to explain.

A hospital exists for one purpose: to help bring to the community it serves the best medical care it is possible to attain. It is far more than a building and equipment. It is a living, functioning thing.

There are three basic groups of people involved. We think first of those that run the hospital—the department heads, the nurses, the technicians, the business office personnel, the service people—all under the direction of the administrator.

Then we think of the doctors—usually independent practitioners—who are responsible for medical care given.

Thirdly, there is the board of trustees.

The legal and moral responsibility for the effective functioning of this unique tripartite organization rests upon the board of trustees. They do not represent administration, nor do they represent the doctors. They represent the community served, and their final responsibility is to the community.

Given the grave responsibility that rests on the board, one might well ask why not have some doctors as board members? There are, I think, very cogent reasons why not.

The doctor's role in the functioning of the hospital is vital and it is *unique*. His point of view is special, his approach to the institution's problems is different from that of the administrator and of the trustees. It is a point of view that must be recognized, respected, and kept vocal and strong. To make one or a group of doctors minority members of a lay board hopelessly undermines the doctor's position. If he speaks, does he speak as a doctor or as a trustee? A question on which a doctor's judgment should be final becomes a question to be decided by a majority vote, with doctors in a minority position. Boards having doctors as members will almost surely find themselves making medical decisions.

And who are these doctors to be, and how will they be chosen? Will they not too often be the favorite doctors of the dominant board members? Does their board position secure favored staff advancement for them, or contrariwise, would it make such advancement difficult? Both would be suspect. Are they acceptable to the balance of the staff, and do they speak for them? If this is the case at the time of their appointment, what is the situation years later when they are old and loved but quite out of touch with current medical concepts?

And what of the administrator's position in dealing with both the board and staff when the board is an ill-defined mixture of both?

This does not mean that at least one doctor should not meet with the board and with the executive committee. On this I also feel strongly. To fail to provide for this would be as ill-advised as to have the board meet without the administrator. But the doctor who does meet with the board should speak as a doctor, for doctors. On certain questions his opinion should outweigh that of the entire board.

Who should this person be? The president of the staff—or the chief of staff—or the pathologist—or the director of the medical service—or even some doctor selected by the staff. Possibly we must create the role of medical director, giving at least part time responsibilities to one particularly qualified man. If we do, we must be prepared to pay out of hospital funds for this added labor and responsibility.

Having doctors as board members is better than having no communication between board and staff, but it is unsatisfactory at best, and will effectively prevent the establishment of any really sound working relationship.

The basic principle seems clear. There are three legs to the stool. Let's not mix them up.

# TASTY-MONIALS

(Shamelessly Culled  
From the Classics)



"My delight and thy  
delight."

—Burdett

"Reason's whole  
pleasure, all the joys  
of sense."

—Pope

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Fluorine (as CaF <sub>2</sub> ) . . . . .	0.1 mg.
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## BOOK REVIEWS

*THE ETERNAL SEARCH.* The Story of Man and His Drugs by Richard R. Mathison. G. P. Putnam's Sons, N.Y., 1958. \$5.95

Just as we consider medicine and methods of treatment of past years primitive and outmoded, so may our present day medicine be considered by future generations. The old wives' tales, superstitions, purging, bloodletting, the plagues and pestilences, the quack remedies and the discoveries of smallpox vaccination, of bacteria, of anesthesia, of penicillin and other antibiotics—all are fascinatingly and often humorously told by the author.

The idea for the book came when he was browsing in San Francisco's Chinatown, in an herb doctor's shop filled with exotic and strange roots, plants and dried animals. He collected material from books, medical libraries, doctors, pharmacists and old people.

There are chapters on medicines used to relieve pain and to escape from one's problems, such as opium and alcohol, and on drugs used for the mentally deranged.

New discoveries of the past and recent years have been breakthroughs—"accidents by trained observers with enough understanding to consolidate their gains." There are many fields of inquiry and research to be pursued.

And it is well, now and again, to look back and study some of the old ways which may still be of use in the world today.

MERLE M. POTTER, M.D.

*SURGERY IN WORLD WAR II. ORTHOPEDIC SURGERY IN THE MEDITERRANEAN THEATER OF OPERATIONS* by Oscar P. Hampton, Jr., M.D. Medical Department, U.S. Army, Office of the Surgeon General, Wash., D.C., 1957. \$4.00

This book presents a very excellent documentation on the subject of wartime orthopedic surgery as developed and practiced in the Mediterranean (previously the North African) Theater of Operations. It gives a short review of orthopedic practices in general use at the end of World War I which, essentially, called for the management of most compound fractures by skin traction for continuous traction. Occasional skeletal traction and

plaster cast fixation were not in general use because freedom of joint motion was considered desirable. During World War I, great emphasis was placed upon the sterilization of a wound in compound fractures. Infection was then combated by local applications of such agents as a combination of bismuth subnitrate, iodoform, and paraffin. Others were treated by the elaborate irrigation method of Carrel-Dakin. However, evaluation at the end of the war indicated that a high incidence of infection had taken place together with a high incidence of malunion and nonunion of fractures.

The method of Carrel-Dakin continued to be used in civilian compound fractures and joint injuries following World War I, but the method was so tedious and troublesome to apply that it gradually became discontinued in favor of the method of H. Winnett Orr in which the wound was left open to secure drainage and the fracture was managed by a skeletal fixation in a plaster cast. Since the closed plaster technique was reported as giving rather satisfactory results by Trueta in the cases that were treated by this method in the Spanish Civil War, this particular method of treatment was given a thorough trial during the early part of the war in North Africa. The general plan of management of compound fractures in the North African Theater of Operations early in World War II was as follows:

"After debridement in a forward hospital, the wound was dressed with vaseline gauze, the fracture was reduced, a plaster cast was applied in which skeletal transfixion pins were sometimes incorporated. The patient was then transferred to a general hospital where, in the absence of the specific indications to the contrary, the cast was left in place for 4-6 weeks. At the end of this time, it was assumed, wound healing would be progressing satisfactorily by granulation, and the fracture would also be well on its way toward healing. In theory, this was not an unsound policy. In practice, it proved unworkable, and the results were poor."

Patients often were rather febrile, the casts often disintegrated and were ineffective. At times, the circulation was threatened. The transfixion pins were often broken and infection was present about the pin openings and often the position was lost.

Because of these poor experiences, the closed plaster technique was gradually abandoned and a new technique for the handling of compound injuries was adopted.

In the Mediterranean Theater of Operations, of 111,125 wounded or injured in action, it is estimated that 79,000 or 71% of the total number sustained wounds of the extremities. A significant proportion of these required orthopedic management. The number of wounds of the extremities in this Theater approximately equaled the total number of wounded or injured in action in the entire Korean War. The closed plaster method of management of compound fractures was for all practical purposes written off early in 1944, because even with the modification which had been introduced, the results were not satisfactory. An analysis of the results furthermore showed that improvement could be accomplished only by a fundamental change in surgical concepts. By the time of the fall of Rome, in June of 1944, the consultant in surgery for the Mediterranean Theater was able to report that up to that time at least 25,000 soft tissue wounds had been closed by delayed primary suture on the indication of their gross appearance alone. Bacterial counts were not made in any of these injuries. In at least 95% of the soft tissue wounds managed by delayed primary suture, healing occurred with no loss of life or limb and without serious complication. The most usual explanation in the 5% of unsuccessful closures was failure to remove residual dead tissue in the deep recesses of the wound before the wound was sutured. Out of the entire studies and experiences, compound battle fractures gave the best end results when their management was conducted in the following sequence:

1. Initial wound surgery in the combat zone.
2. Reparative surgery in the communications zone.
3. Reconstructive surgery, if necessary, in the Zone of the Interior.

Treatment in the combat zone consisted of the application of sterile occlusive dressings, the control of hemorrhage by compression dressings, and in some cases by the application of a hemostat or a tourniquet, the administration of morphine in limited doses, plasma transfusions, emergency splinting and booster doses of tetanus toxoid and the institution of chemotherapy.

The second phase in the management of compound fractures consisted of excisional or reparative surgery or both. Four to seven days after wounding was regarded as the optimum time for the reparative stage of wound surgery and particularly for the closure of a compounding wound, though a maximum of ten days was still within permissible limits. From the physiological standpoint, the time

lapse of four to seven days between initial and reparative surgery allowed for the sequestration of bits of residual devitalized tissue which had been overlooked or which could not be excised at initial wound surgery. By the end of this particular interval, it was possible to make a decision concerning the viability of questionably devitalized tissue which had been deliberately left *in situ* at the first operation. At this operation, all devitalized tissue, as stated, was removed and internal fixation *per se*, which was really not the objective of the reparative surgery program, was used when indicated and this was done by means of fixation by plating, multiple screws or wire.

The third phase of the surgery was always done in the Zone of the Interior and this consisted largely of the treatment of ununited fractures by refreshing of the bone ends with plating, bone grafting plus the attempt at repair of severed nerves with gapping together with tendon repairs and transplants.

After learning that the methods described were of value in the management of compound fractures, the same form of treatment was applied to the management of compound wounds of joints with equally good results.

With reference to amputations, throughout the 2½ years of line warfare in the Mediterranean Theater of Operations, the attitude toward amputation was one of extreme conservatism on the part of all the medical officers. Because of the tremendous possibilities of modern reconstructive surgery, the operation was almost never performed unless the extremity was damaged beyond salvage or unless after salvage had been attempted, conditions developed which endangered life or made further effort to save the limb futile. The indications which are given for amputation were as follows:

1. Trauma at wounding in which the extremities were blasted off, blown off, torn off or shot away.

*concluded on page 140*

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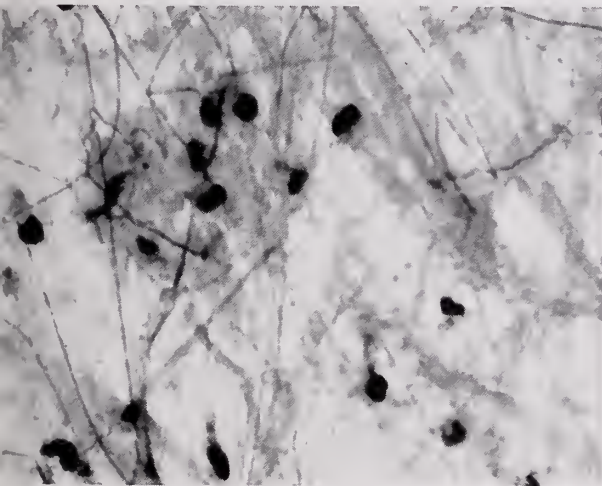
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## BOOK REVIEWS

concluded from page 137

2. Vascular insufficiency *per se*. In this type of case, the reason for the amputation was the interruption of major blood vessels with the resulting gangrene or impending gangrene.
3. Infection.
4. Disease including malignant tumors, trench foot, thrombosis, tuberculosis and other conditions.

The book also deals with non-combat orthopedic conditions which included fractures plus non-combat-incurred lesions including painful feet, painful backs, painful and unstable knees, recurrent dislocations of the shoulder and old fractures of the scaphoid bone. In these types of lesions, surgery was rarely done. Most of the soldiers affected were given limited duty.

Soldiers who could not be returned to active duty within 90-120 days were evacuated to the Zone of the Interior as soon as was compatible.

In conclusion, the subject of wartime orthopedic surgery is very well covered and well documented in the volume.

The book is recommended for reading to the medical student, general surgeon, orthopedic surgeon and traumatic surgeon.

A. A. SAVASTANO, M.D.

**YOU CAN INCREASE YOUR HEART-POWER** by Peter J. Steincrohn, M.D. Doubleday & Company, Garden City, N.Y., 1958. \$4.95

Dr. Steincrohn has written a comprehensive book divided into fifteen major parts. Each part, dealing with one phase of real or imaginary heart disease as experienced by people, is explained by question and answer technique. Much of his material is obtained from articles he has written for his nationally syndicated columns.

This book has great appeal for the layman and could well be used by physicians as recommended reading for their patients needing better understanding of the cardiovascular system. It has helped several of my cardiac patients who have found themselves to have a happier, less worrisome existence and more able to follow a healthy medical regime.

STANLEY E. CATE, M.D.

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MARCH, 1959

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See page 175

*Volume XLII, No. 3*

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Hodgkinson, C. P.; Igna, E. J., & Bukeavich, A. P. *Ann. New York Acad. Sc.* 71:753, 1958.



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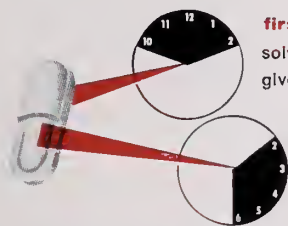
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<sup>†</sup>Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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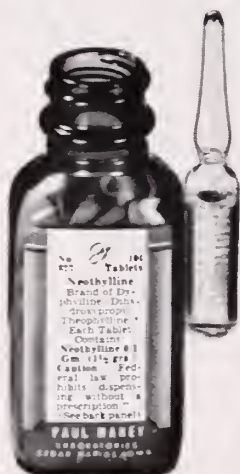
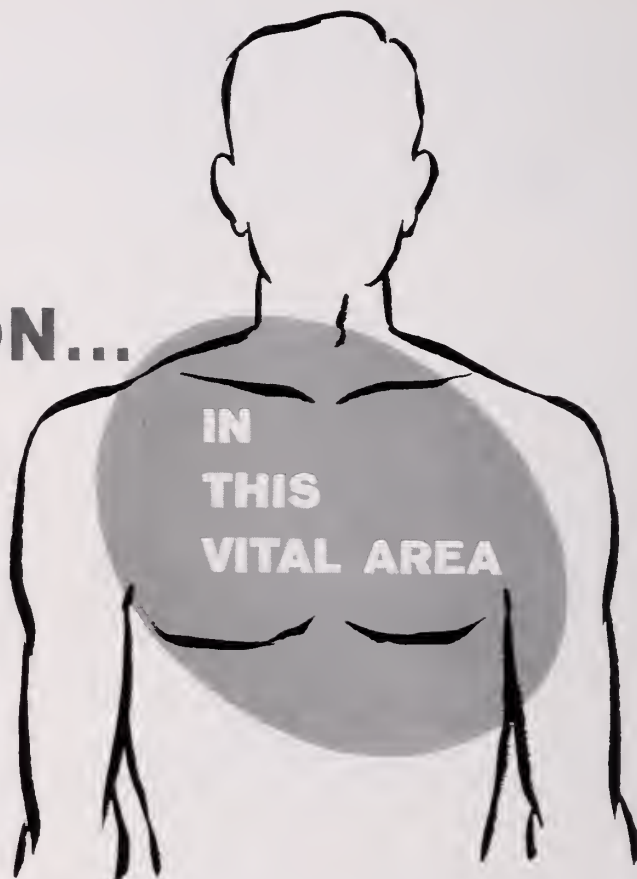
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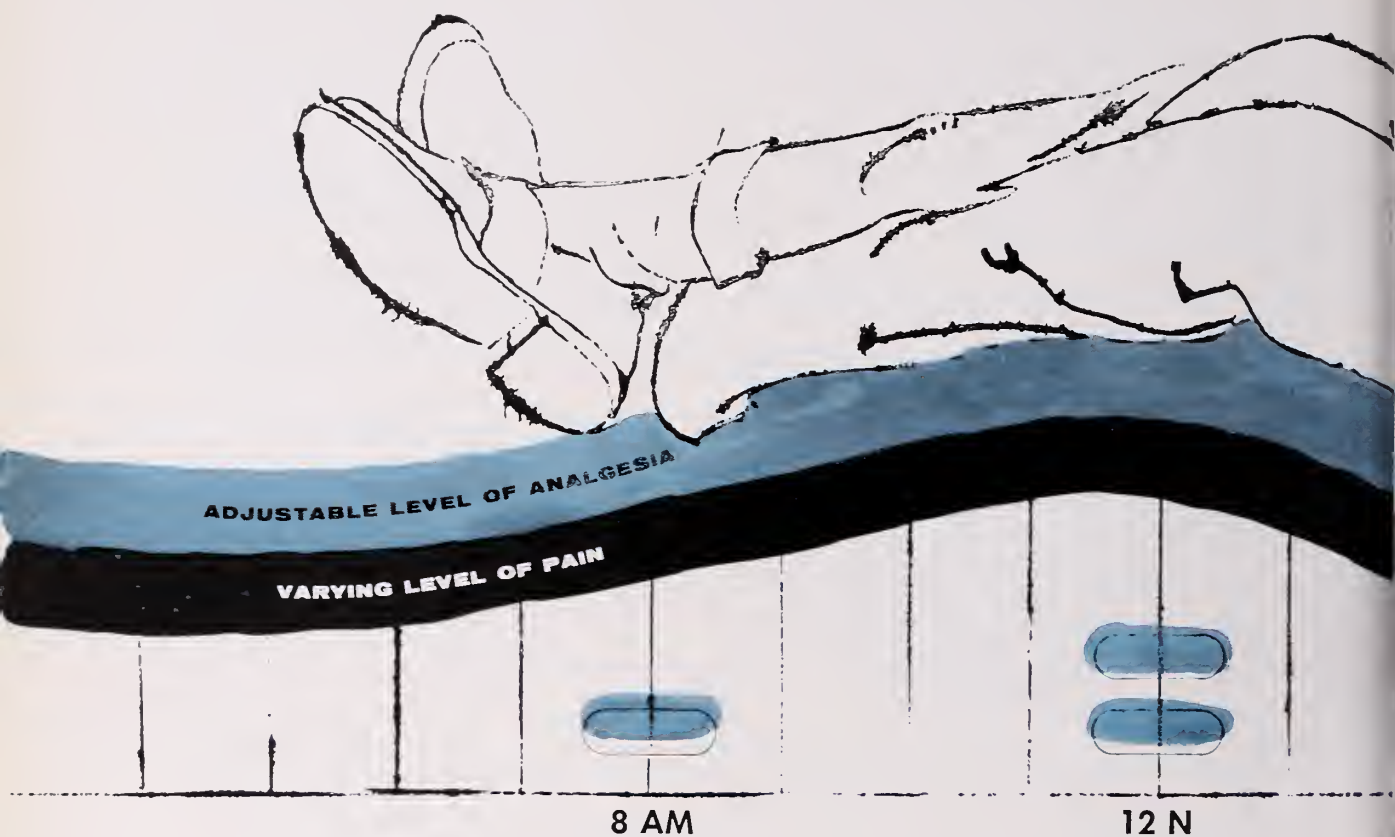
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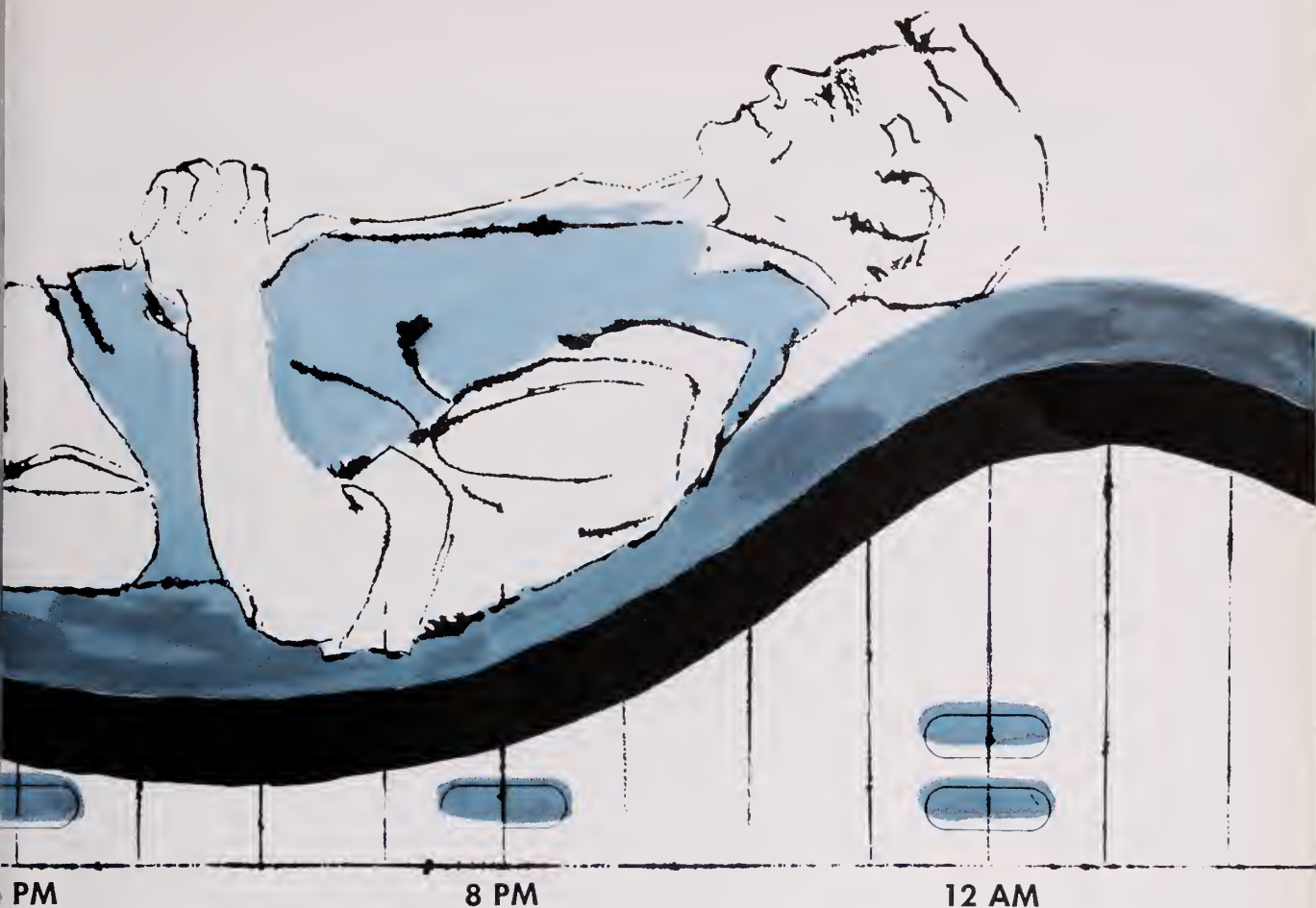
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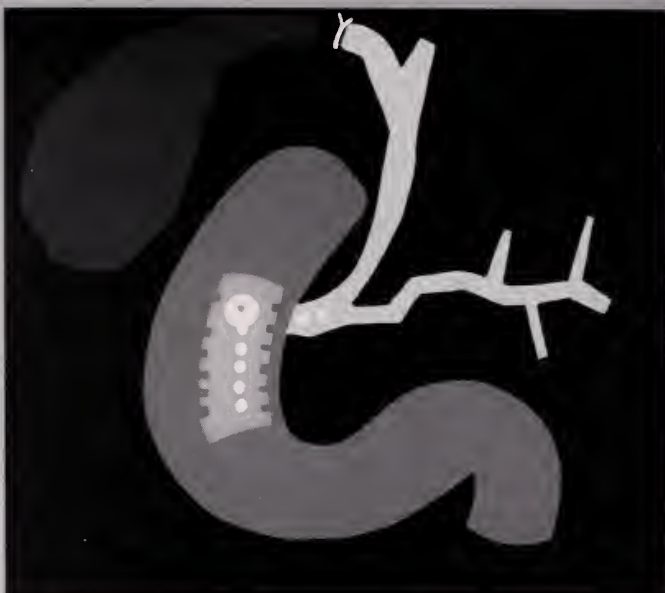
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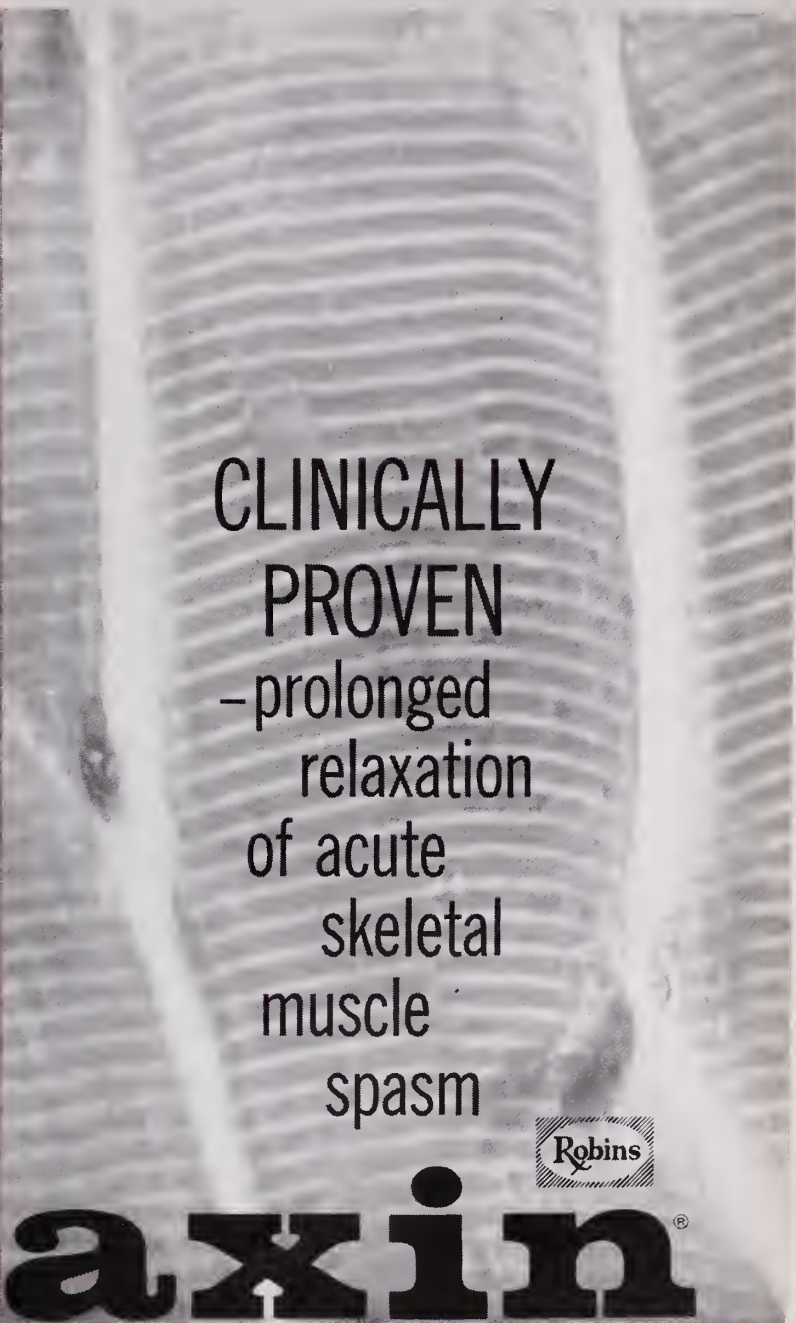
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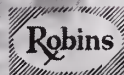
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REFERENCES: 1. Carpenter, E. B.: Southern M. J. 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Lewis, W. B.: California Med. 90:26, 1959. 4. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 5. Park, H. W.: J.A.M.A. 167:168, 1958. 6. Plumb, C. S.: Journal-Lancet 78:531, 1958.

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# The RHODE ISLAND MEDICAL JOURNAL

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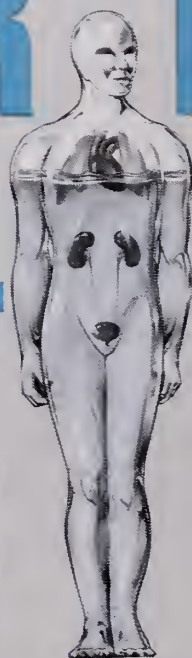
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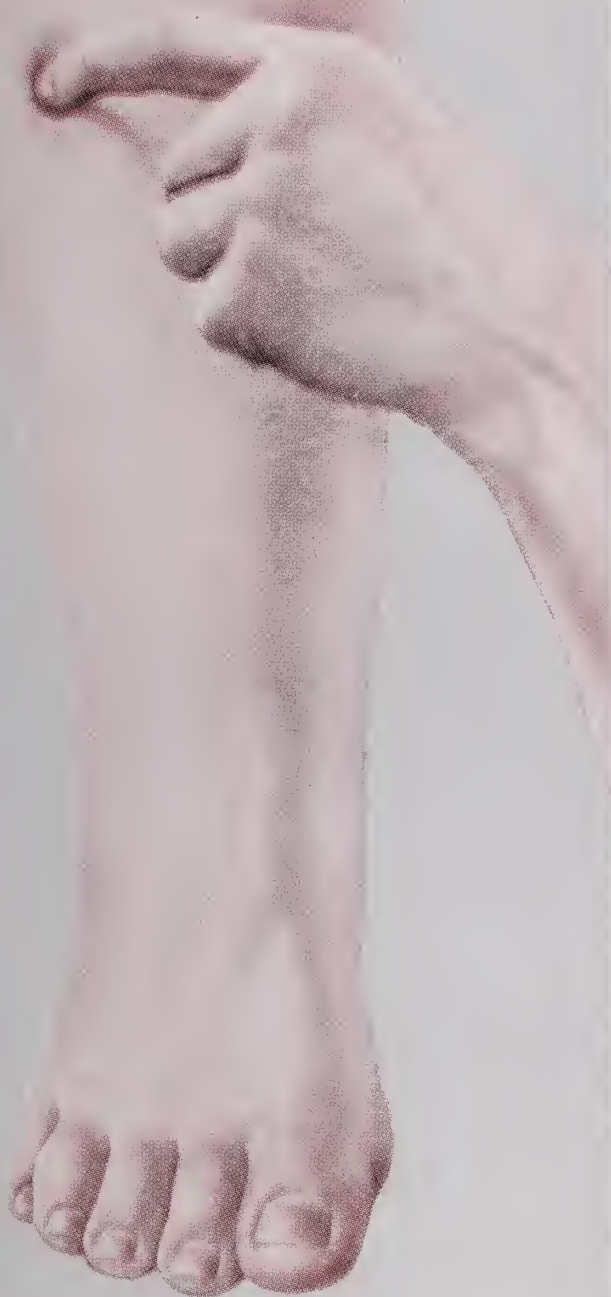
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1. Landes, R. P. and Peters, M.:  
Postgrad. Med. 23:648, June 1958.

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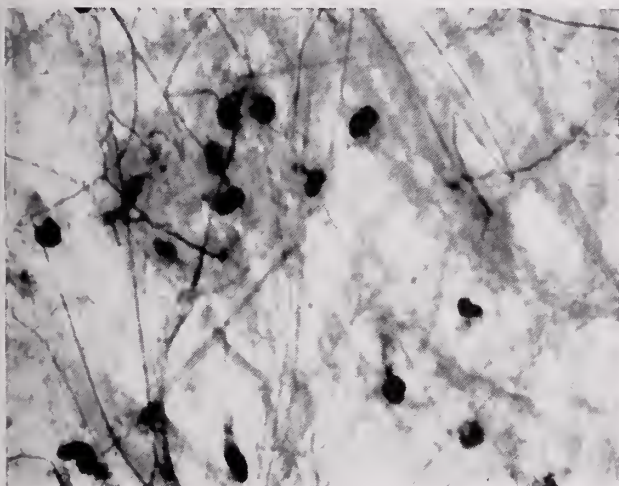
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## SOME ERRORS IN THE DIAGNOSIS OF GASTROINTESTINAL NEOPLASMS\*

O. M. JANKELSON, M.D.

The Author, O. M. Jankelson, M.D., of Boston, Massachusetts. Assisting Physician, I and III (Tufts) Medical Services, Boston City Hospital, and the Department of Medicine, Tufts University School of Medicine.

A NEGATIVE APPROACH to diagnosis, based on a discussion of errors, can serve to place the various diagnostic modalities in proper perspective. Although it may appear to emphasize limitations in diagnosis, such an analysis should allow a critical evaluation of the use of diagnostic aids. Because of the limitations of space some arbitrary exclusions must be made and the following will not be discussed: errors in the differential diagnosis of gastric "ulcer-cancer"; failures in the diagnosis of pancreatic tumors, since the diagnosis is difficult, largely unsupportable by laboratory tests, and made primarily by diagnostic awareness; and mistakes in the differentiation of malignancy and benignancy in such tumors as polyps, since the diagnosis is dependent on microscopic examination and clinically these tumors must be considered malignant until proven otherwise. There remains a considerable number of diagnostic errors, both of omission and of commission.

### Errors of Omission

Errors of omission (Table I) are consummated by both patients and physicians. The problem of patient delay in presenting himself for medical attention has received considerable attention.<sup>1</sup> A wide dissemination of information has been advocated to reduce this factor. Its prospective value is doubtful, as indicated by the insignificant reduction in delay encountered when physicians are patients.<sup>2</sup>

Physicians' failures, primarily a lack of appreciation of signs and symptoms that can serve as clues

\*Delivered in part at the Teaching Program on Cancer for invited general practitioners, at Rhode Island Hospital, Providence, Rhode Island, October 26, 1958.

From I and III (Tufts) Medical Services and the Gastrointestinal Clinic, Boston City Hospital and the Department of Medicine, Tufts University School of Medicine.

to otherwise occult gastrointestinal cancer (Table II), are also a source of delay. The significance of these omens is greater in, but not limited to, patients over forty years of age. The appearance of these symptoms necessitates full investigation until a diagnosis has been established. Symptomatic therapy, even if temporarily effective, is not a substitute.

An *unexplained change in digestive pattern* is an early and frequent symptom of gastrointestinal cancer. In meticulous histories of patients with gastric carcinoma there is an interval of vague complaints, such as abdominal fullness, "gas," indigestion, and loss of appetite, occurring prior to the appearance of more diagnostic symptoms.<sup>3</sup> Similar symptoms have been noted with neoplasms of the cecum and ascending colon,<sup>4</sup> emphasizing the importance of complete investigation of the entire gastrointestinal tract. Unfortunately, the diagnostic quality of these symptoms is somewhat reduced by their occurrence in functional disorders. Nevertheless, their significance must not be underestimated.

The importance of *alterations in bowel habits* as an early warning of colonic cancer has been frequently emphasized. The alterations, consisting of constipation, diarrhea, or both alternating, are almost universal with tumors of the left side of the colon. *Intestinal obstruction*, especially partial, can be included under this heading. The recent appearance of abdominal cramps, fullness, and distention preceding defecation occurs often as the initial

TABLE I  
Errors of Omission  
Patient Delay  
Physicians' Failure

TABLE II  
Clues to Gastrointestinal Neoplasms  
Unexplained changes in digestive pattern  
Unexplained alterations in bowel habits  
Unexplained intestinal obstruction  
Unexplained gastrointestinal hemorrhage  
Unexplained fever  
Unexplained anemia

*continued on next page*

symptom of colonic cancer. In the more dramatic episodes of intestinal obstruction, such as intussusception, polypoid tumors may be the leading point or precipitating factor.

The diagnosis of cancer is almost established when these alterations in bowel function are accompanied by *gastrointestinal hemorrhage*. It may be well, especially in older patients, to consider all instances of gastrointestinal bleeding as due to cancer until proven otherwise. With cancer bleeding is most often microscopic in amount, demonstrable only by chemical tests. On occasion it may be gross, rarely even massive. Gross bleeding may occur as the passage of changed or unchanged blood in the vomitus—indicating a lesion proximal to the ligament of Treitz; as changed blood in the stool, characteristically a tarry black, partially formed stool—indicative of a lesion proximal to the cecum; or as bright red blood per rectum—occurring with lesions anywhere in the gastrointestinal tract.<sup>5</sup>

*Unexplained fever* has received inadequate attention as a clue to gastrointestinal cancer. It is seen frequently in patients in whom the diagnosis has been established and may occur prior to this event.<sup>6</sup> It is most marked in the presence of extensive ulceration,<sup>6</sup> especially with gastric tumors.<sup>7</sup> It is not specific for gastrointestinal tumors and is best known with the lymphoma-leukemia group of diseases<sup>8</sup> and hypernephromas.<sup>9</sup>

Of all these clues *unexplained anemia* is of the highest significance. The investigation of a patient with unexplained anemia must include examination of the stools for evidence of occult blood, digital rectal and sigmoidoscopic examinations, plus radiographic investigation of the gastrointestinal tract with particular reference to the cecum and ascending colon.

### Case I

A sixty-seven-year-old female was referred for barium enema. She had been seen elsewhere eight months before and a microcytic anemia had been discovered. Extensive investigation had been directed toward the blood and blood forming organs, the thyroid, and the genitourinary tract without revealing the source of the blood loss. Eight months after the discovery of the anemia a barium enema was performed (Figure 1): three discrete tumors were visualized. At laparotomy the three tumors plus hepatic metastases were found.

The failure to perform an adequate physical examination, including digital rectal, is also a significant error of omission. The importance of the rectal examination is indicated by the occurrence of 70% of all colonic cancers within the reach of the examining finger.<sup>10</sup> Sigmoidoscopy has also been advocated as part of the physical examination, a 10%

incidence of polyps on routine sigmoidoscopies has been reported. When the examinations were repeated on a yearly basis the incidence increased to 20%.<sup>11</sup> But when disease is suspected sigmoidoscopy is as essential as roentgen examination. It allows, with minimal patient discomfort, full visualization plus the opportunity of biopsy over the lower 25 centimeters of the colon. Seventy-five per cent of all colonic cancers occur within this area.<sup>10</sup>

Another form of physician error is the failure to allow for the possibility that cancer coexists with other disease. A pre-existing diagnosis may be relied upon as the explanation of all developments and an opportunity to discover a concomitant neoplasm will be lost. Because diverticulosis and cancer of the colon occur largely in the same age groups these two diseases are often coexistent.

### Case II

An eighty-year-old male was seen in the Out-Patient Department of the Boston City Hospital with the complaint of diarrhea. Episodes had occurred previously three and four months before. All three had appeared to respond promptly to mild constipating agents. A barium enema had shown diverticuli of the colon. Repeat X ray of the colon at this time revealed numerous diverticuli in the distal colon with isolated areas of spasm and mucosal alterations, consistent with diverticulitis. However, there was also a constant and irregular filling defect of the cecum (Figure 2).

### Errors of Commission

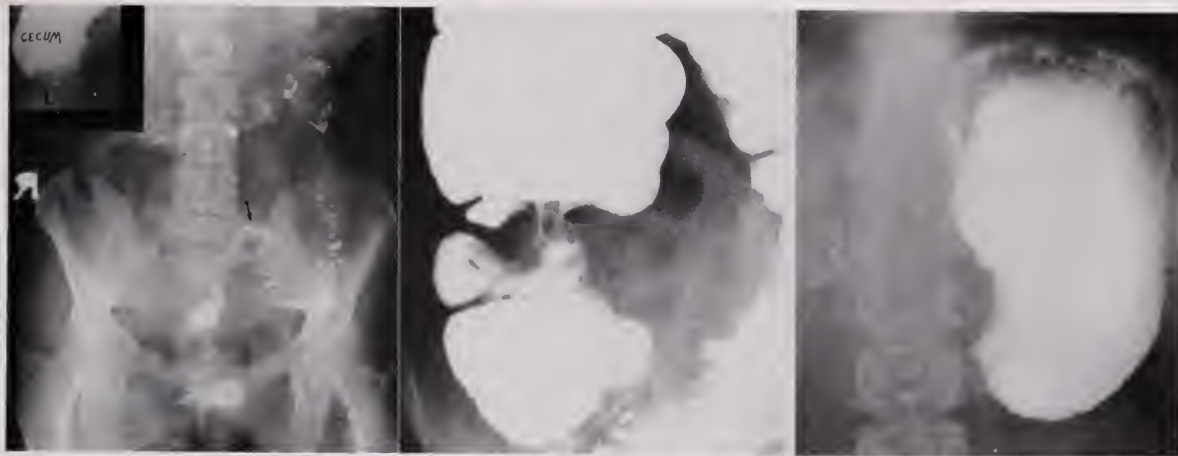
The errors of commission (Table III) are due to the inherent limitations of the diagnostic tools used in the investigation of the gastrointestinal tract. They are either a failure to demonstrate a lesion—a "false negative"—or an erroneous diagnosis of a non-existent lesion—a "false positive." The prime responsibility for these errors, however, resides not with the method but with the interpretation.

X ray is the chief investigative tool for examination of the gastrointestinal tract. It is widely available, but not uncomfortable or hazardous for the patient, and under suitable conditions is highly informative. Adequate preparation of the patient is essential and in its absence the information obtained may be insufficient for diagnostic purposes.

TABLE III  
Errors of Commission

X ray  
Gastroscopy  
Cytology





FIGURES 1, 2, 3

Case I. Barium enema (air contrast study) with three tumors (arrows).

Case II. Sigmoid colon with diverticuli on right, cecum with filling defect on left.

Case III. Distended stomach evidencing pyloric obstruction.

#### Case III

A fifty-one-year-old female had had a cholecystectomy eleven months previously. At that time palpation of the stomach by the surgeon had failed to reveal any abnormalities. At this time she complained of symptoms of pyloric obstruction of short duration. Upper gastrointestinal examination was performed after evacuation of the stomach content through an Ewald tube. The stomach was distended, atonic, and considerable residue was present (Figure 3). Although the clinical picture had suggested the possibility of neoplastic disease the diagnosis could not be confirmed by this examination. At laparotomy a malignant tumor of the distal stomach was found.

Even under the best of circumstances roentgen examination of the stomach may fail to demonstrate about 10% of all cancers.<sup>12</sup> The incidence of these "false negatives" is higher when the lesion is located in the proximal third of the stomach, where neither palpation nor pressure techniques can be utilized.<sup>13</sup>

"False positive" reports also occur, but statistics on their incidence are limited.<sup>14</sup> The list of diseases misdiagnosed as cancer is long and includes inflammatory and granulomatous diseases, amyloidosis, varices, and pressure from adjacent organs. Organic diseases are not the only offending conditions, retained food or blood can cause confusion.

#### Case IV

A sixty-eight-year-old male was admitted to the Boston City Hospital with complaints of loss of appetite and weight. Physical examination was non-contributory. By barium meal a polypoid filling defect in the mid-portion of the stomach was seen (Figure 4). At laparotomy the stomach was normal by palpation and inspection through a gastrotomy. Retrospective analysis indicated that the patient had eaten just prior to X ray.

Blood clots in the stomach may also be a source of confusion. Roentgenologists are properly reluctant to place undue emphasis on polypoid defects in the face of known upper gastrointestinal hemorrhage. However, a lesion may be obscured by the clots and a "false negative" occur.

#### Case V

A fifty-four-year-old male, a chronic alcoholic, entered the hospital with signs and symptoms of acute anemia. On gastric aspiration fresh blood was obtained. X-ray examination revealed multiple defects which were interpreted as blood clots (Figure 5). Repeat examination was performed after the bleeding had stopped and a large polypoid tumor was seen. At operation the diagnosis was confirmed.

*continued on next page*



FIGURE 4

Case IV. Polypoid filling defects in the body of the stomach.

In the colon roentgen examination is somewhat more accurate and "false negative" reports are estimated at about five per cent.<sup>15</sup> Most of these occur either with lesions in the rectosigmoid or cecum or in the presence of coexistent disease. Failures to visualize a lesion in the rectosigmoid will be of least clinical significance if digital rectal and sigmoidoscopic examinations are properly utilized. "False negative" reports due to inadequate visualization of the cecum are of greater import. Without filling of the cecum, as demonstrated by regurgitant flow into the terminal ileum or filling the appendix, a barium enema is considered incomplete. A space occupying lesion in the cecum, which need not obstruct the fecal stream, may produce the identical appearance. Such a lesion may in some instances be more easily visualized by filling the terminal ileum and cecum from above by barium by mouth.

"False negatives" also occur when other diseases, notably diverticulitis (Cf. Case II) and chronic ulcerative colitis, confuse the picture. In the presence of both diseases the diagnosis of cancer is difficult, since the symptoms may be indistinguishable and by X ray preceding colonic deformities—spasm or obstruction in diverticulitis, polypoid degeneration or cicatrization in colitis—may mask or mimic neoplastic changes. In chronic ulcerative colitis, furthermore, alterations in exfoliated cells often resemble those of cancer.<sup>16</sup>

The problem of "false positive" reports on barium enema examinations is of less importance because of their relative infrequency. As in the examination of the stomach the errors are largely due to the confusion produced by other diseases.

#### Case VI

A sixty-three-year-old female was admitted to the hospital because of the passage of bright red blood per rectum. Abdominal cramps had preceded bowel movements but were not a prominent complaint. A barium enema revealed a narrowing in

the descending colon (Figure 6). In thirteen days the area of narrowing was longer and the constriction was more pronounced (Figure 7). The constricted segment was resected. On microscopic examination there was hypertrophy of smooth muscle cells with foreign body giant cells, interpreted as a variant of segmental colitis. In the succeeding three years there have been no recurrent symptoms and repeat barium enemas have failed to reveal any further pathology.

Segmental colitis may be confused both clinically and by roentgen examination with cancer of the colon. It is characterized by a short course, during which bleeding and obstructive symptoms predominate. Evidence of acute inflammation, as in the usual forms of ulcerative colitis, is absent or inconspicuous. The treatment of choice appears to be resection with end-to-end anastomosis; the recurrence rate is probably very low.<sup>17</sup>

*Gastroscopy* is primarily of value in obtaining further information when the X-ray reports are inconclusive. It may also allow correction of an error in the X-ray diagnosis. It has been most successful when gastritis, especially in the antrum,<sup>18</sup> has simulated malignancy on upper gastrointestinal series.<sup>19</sup>

However, there are inherent limitations to gastroscopy. Patient co-operation and a patent esophagus are essential. Some areas of the stomach are inaccessible and retained secretions, food, or blood may obscure the mucosa also and allow "false negatives" to occur.

#### Case VII

A seventy-four-year-old male was admitted to the hospital with an inadequate history due to language difficulties. His presenting complaint was hematemesis. Physical examination was noncontributory. On upper gastrointestinal series the fundic area was thought to be suspicious but no definite diagnosis was made. On gastroscopy a nodular mass was seen in this area but the mucosa



FIGURES 5, 6, 7

Case V. Multiple filling defects in fundus of stomach.

Case VI. Area of narrowing in descending colon.

Case VII. Increase in area of involvement in thirteen days.



was obscured by oozing blood. A presumptive diagnosis of cancer was made. At operation the mass was found to be gastric varices associated with advanced cirrhosis of the liver.

Even with adequate visualization errors of interpretation on the part of the gastroscopist may occur.

### Case VIII

A fifty-seven-year-old male was admitted with indeterminate symptoms and signs of a profound anemia. Stools were consistently positive for occult blood. Gastroscopy was performed when the roentgenologist failed to discover a source of the bleeding. On the posterior wall of the stomach there was an area of erosions with mucosal irregularity and rigidity of the wall, suggesting malignancy. In the succeeding year this diagnosis was not confirmed by the clinical course, repeat X rays and gastroscopy, and exfoliative cytology.

*Cytologic examination* of exfoliated gastric cells by the Papanicolaou technique has attained a high degree of reliability, approaching that reported with vaginal and bronchial secretions. However, the acidity of the gastric contents necessitates great care in order to obtain adequate and well-preserved specimens. With such careful technic a correct cytologic diagnosis has been made in 84 per cent of cases of gastric cancer.<sup>20</sup> The significance of a positive report is emphasized by the occasional discovery of hitherto unsuspected gastric carcinoma.<sup>20, 21</sup>

However, "false negative" reports are not infrequent. In addition, the occasional "false positive" imposes limitations on the reliability.

### Case IX

A seventy-three-year-old male was first seen in the Out-Patient Department with the complaint of constipation. Because of a story of post-prandial distress and easy satiation an upper gastrointestinal series was performed. There was diminished peristaltic activity and the possibility of linitis plastica was suggested. Exfoliated gastric cells were interpreted as positive for malignancy by several observers. An exploratory laparotomy was performed and no abnormalities in the stomach were found. A biopsy was interpreted as chronic gastritis. The individual cells throughout the biopsy were strikingly similar to the exfoliated cells.

## SUMMARY AND CONCLUSIONS

In certain instances difficulties and mistakes are encountered in the diagnosis of gastrointestinal cancer. Evaluation of each patient individually by all available diagnostic tools may reduce the frequency of these errors. The final responsibility for diagnosis cannot be delegated to the roentgenologist, the gastroscopist, or the cytologist but must rest upon the referring physician. When the diagnosis remains doubtful after evaluation and correlation of the reports, one or all of the tests may be

repeated until inconsistent findings are reduced to a diagnostic pattern. In some instances the final diagnostic tool, exploratory laparotomy with microscopic examination of the resected specimen, may be required.

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I wish to thank Doctor I. R. Jankelson for permission to report Cases I and III and Mr. Leo Goodman, Mallory Institute of Pathology, Boston City Hospital, for the photographs.

## BIBLIOGRAPHY

- <sup>1</sup>Robbins, G. F.; Conte, A. J.; Leach, J. E., and MacDonald, M.: Delay in Diagnosis and Treatment of Cancer, *J.A.M.A.*, 143:346 (May 27) 1950
- <sup>2</sup>Colcock, B. P.: Diagnosis of Carcinoma of Right Colon, *Postgrad. Med.*, 22:151 (Aug.) 1957
- <sup>3</sup>Myers, H. C.: Early Diagnosis of Carcinoma of the Stomach, *J.A.M.A.*, 163:159 (Jan. 19) 1957
- <sup>4</sup>Bockus, H. L.: *Gastro-Enterology*, W. B. Saunders Co., Phila., 1944, v. ii, p. 757
- <sup>5</sup>Hilsman, J. H.: The Color of Blood-Containing Feces Following the Instillation of Citrated Blood at Various Levels of the Small Intestine, *Gastro.*, 15:131 (May) 1950
- <sup>6</sup>Clanton, E. L.: Fever in Carcinoma of the Colon and Rectum, *Am. J. Surg.*, 80:459 (Oct.) 1950
- <sup>7</sup>Chapnick, H. A.: Diagnosis Difficulties in Carcinoma of the Colon, *J. Mich. Med. Soc.*, 56:471 (Apr.) 1957
- <sup>8</sup>Gall, E. A., and Mallory, T. B.: Malignant Lymphoma, *Am. J. Path.*, 18:381 (May) 1942
- <sup>9</sup>Böttinger, L. A.: Fever of Unknown Origin. IV. Fever in Carcinoma of the Kidney, *Acta med. scand.*, 156:477 (Feb. 2) 1957
- <sup>10</sup>Hodges, F. J., and MacMillan, H. C.: Important Clinical Dividends from X-ray Examination of Colon, *J.A.M.A.*, 147:1191 (Nov. 24) 1951
- <sup>11</sup>Enquist, I. F.: Incidence and Significance of Polyps of Colon and Rectum, *Surg.*, 42:681 (Oct.) 1957
- <sup>12</sup>LaDue, J. S.; Murison, P. J.; McNeer, G., and Pack, G. T.: Symptomatology and Diagnosis of Gastric Cancer, *Arch. Surg.*, 60:305 (Feb.) 1950
- <sup>13</sup>Eisenbud, M., and Finby, N.: Carcinoma of the Proximal Third of the Stomach: A Critical Study of Clinical Observations in 74 Cases, *Ann. Int. Med.*, 46:43 (Jan.) 1957
- <sup>14</sup>Jankelson, O. M., and Kaplan, M.: Non-Neoplastic Masses of the Stomach, To Be Published
- <sup>15</sup>Buser, J. W.; Kirsner, J. B., and Palmer, W. L.: Carcinoma of Large Bowel: Analysis of Clinical Features in 478 Cases, Including 88 Five Year Survivors, *Cancer*, 3:214 (March) 1950
- <sup>16</sup>Galambos, J. T.; Masscy, B. W.; Klayman, M. I., and Kirsner, J. B.: Exfoliative Cytology in Chronic Ulcerative Colitis, *Cancer*, 9:152 (Jan.-Feb.) 1956
- <sup>17</sup>Branch, C. D., and Sledge, C. B.: Inflammatory Lesions of the Colon Simulating Neoplasms, *Gastro.*, 28:981 (June) 1955
- <sup>18</sup>Berg, H. M.: Antral Gastritis, *Radiol.*, 59:324 (Sept.) 1952
- <sup>19</sup>Klotz, A. P.; Kirsner, J. B., and Palmer, W. L.: An Evaluation of Gastroscopy, *Gastro.*, 27:221 (Aug.) 1954
- <sup>20</sup>Graham, R. M.: Diagnosis of Cancer of Internal Organs by Papanicolaou Technic, in *Advances in Internal Medicine*, ed. by W. Dock and I. Snapper, Year Book Publishers Inc., v. VI, 1954
- <sup>21</sup>Laezlo, D.; Colmer, M. L.; Silver, G. B., and Standard, S.: Errors in Diagnosis and Management of Cancer, *Ann. Int. Med.*, 33:670 (Sept.) and 991 (Oct.) 1950



## THE PHARMACOLOGICAL REVOLUTION\*

JAMES A. WATT, M.D.

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IN SPEAKING on such a topic as *The Pharmacological Revolution*, I hesitate a bit over whether to address you as fellow beneficiaries or fellow sufferers. I suspect that most of you are both. For, although I am sure that all of you have been active participants in this revolution, and that all of you have reaped tremendous benefits from the resulting advances in drug therapy, I am also sure that most of you have complained bitterly at one time or another about some of the problems that such advances seem always to create.

I also wonder whether "revolution" is the most suitable word to describe these advances. For what we now call our "modern" approach to pharmaceuticals and to drug therapy is actually the culmination of events that began as far back as the time of Ehrlich and the "Magic Bullet."

Yet it is also true that, as recently as the time when most of us were still studying pharmacology and materia medica in medical school, there was an appalling lack of specific drugs. At my medical school, for example, I was told that there were two specifics: quinine, for malaria, was one; and morphine, for almost everything else, was the other. Of course, there were the heavy metals, and arsenicals for syphilis, but few specific means of therapy for treating the disease by attacking the causative organism.

In a sense the revolution really began with the sulfonamides, which opened up the field of antibacterial agents and brought specific therapy into focus. Almost incidental were the observations that led to the discovery of penicillin, thus starting a revolution which gave us modern "magic bullets" never conceived of before.

But the real revolution, as I conceive of the term—a conscious, directed effort to develop specific drugs to combat specific diseases or to fill specific needs—began with the antimalarial program started during World War II. This program, which devel-

oped as a result of a need to do something about malaria, resulted in the development or synthesis of more than 20,000 compounds in an attempt to find the ultimate antimalarial. The results of this concerted effort have been amazing; but, although effective drugs have already been developed, there are still problems to be solved.

For example, the most active antimalarial developed thus far, pyrimethamine (Daraprim), is almost fantastically potent. It will effectively suppress malaria if administered in 8-10 mg. doses once a week. However, good as this drug is, it is not yet good enough. Unfortunately, many malaria victims cannot be reached for treatment this often. What is needed is a depot antimalarial which is equally effective, but which is so stable *in vivo* and is retained so tenaciously in the tissues that a treatment every six months or even once a year will be effective. Such a drug would be a big step towards wiping out malaria all over the world.

The reason for this is interesting. Quinine and other antimalarial drugs will destroy the blood form of the disease organism; however, the tissue form, which brings about relapses, is harder to kill. Since mosquitoes became infected from the blood of malaria victims, a drug that would destroy the blood organism for as long as six months or more, coupled with the mosquito's short life span, would eliminate the disease by eliminating the infected mosquitoes.

An interesting question might be raised at this point: If we were able to go so far toward the truly effective antimalarial in such a short time through this concerted effort, why did we put up with relatively ineffective treatment for so long before doing anything about it? I think that the answer is this: when forced, we can always advance far more rapidly than we think.

Another revolution presently in progress is the chemotherapeutic attack on cancer. And although the results thus far have not been so spectacular, as in the case of malaria, great progress is being made.

Four years ago, acting upon the advice of leading scientists aware of the interesting possibilities of modifying tumor growth by drugs, the Congress set up the Cancer Chemotherapy Program. This program is carried on at the National Chemotherapy Service Center under the administration of the National Cancer Institute.

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\*Delivered at the 112th Annual Meeting of the Providence Medical Association, at Providence, Rhode Island, January 5, 1959.

Recruiting its advisory groups from the pharmaceutical industry, from medical practice, and from cancer research groups all over the country, the Service Center has now set up the necessary machinery for screening from 40,000 to 50,000 compounds per year by testing them against three tumors occurring in mice. If the compound tested produces modifications in these tumors, the green light is given for further testing.

Many of these compounds come from rather unusual supply depots. One such depot is the shelves of college chemistry laboratories, which contain a fantastic number of compounds synthesized by chemistry students as part of their graduate work. These compounds had never been tested, and nobody knew what they might be good for. A similar source is laboratories of our pharmaceutical houses, whose shelves also contain hundreds of compounds synthesized as by-products of other programs. But while these houses felt that the compounds were good for *something*, they felt that the cancer therapy field was still too experimental and risky to justify investing the necessary funds for the complete testing process—a process which might cost \$500,000 for a complete run-down on one compound.

However, the 40,000-50,000 compounds I spoke of earlier do not get this full treatment. Because only about one out of a thousand of these compounds demonstrates effective tumor-damaging power, only forty or fifty of the thousands tested thus far have shown enough promise to merit further studies leading towards clinical trial.

Another supply source, however, shows more promise. This is the antibiotic "beers" or "soups" from which streptomycin and certain other antibiotics are isolated. These beers contain products of bacterial growth which have shown effective tumor-damaging power. But even more important is the fact that about one in a hundred of these "beers" shows promise, as opposed to the one in a thousand ratio for drugs from the shelves. And oddly enough, the compounds extracted from antibiotic beers of the Japanese pharmaceutical industry show a higher degree of tumor-damaging power than those of the United States.

At present about 100 "beers" have shown enough promise to merit isolating the active principle as a preliminary to clinical trial in man, but how soon this particular revolution will come to its desired conclusion—the conquest of cancer—can only be guessed. It is surprising how often in the course of a logical, methodical attack on a disease problem, the real means of victory comes in through the back door, as did penicillin during the attack on syphilis. However, I suspect that victory over cancer will not be achieved in this backdoor manner, for we are dealing not with a single disease entity but with a

whole series of them. It will take long planned thoughtful work, but there are logical grounds for the belief that cancer will be conquered in the not-too-distant future.

The third revolution that I wish to discuss—one in which I participate a little more directly and thus find the most fascinating—is that taking place in the heart disease field.

Some years ago, Doctor Irvine Page, a physician interested in the chemistry of the brain, somehow got sidetracked into the study of hypertension. In seeking the cause of high blood pressure, he isolated and later crystallized a vasoconstrictor substance which he called serotonin.

Because he had isolated this substance by processing literally gallons of pig's blood, it was naturally assumed that serotonin did its work in the bloodstream by vasoconstriction of the blood vessels. However, when the compound had been crystallized and its chemical formula characterized, it was found that serotonin was identical with Enteramine, isolated in impure form from the gastrointestinal tract by the Italian physiologist Erspamer. A little later it was discovered that serotonin occurred widely in nature, not only in the blood of mammals, but in the skins of toads and in certain toadstools.

This wide distribution of serotonin led quite naturally to the supposition that it had a biological significance far out of proportion to that indicated by its rarity in the bloodstream. Since the serotonin in the blood is trapped entirely in the platelets, it probably has little vasomotor constrictive action. Workers at the Heart Institute have found that stripping the platelets of serotonin has no effect upon the bleeding time or the clotting power of the blood.

Although the largest quantities of serotonin are found in the intestinal mucosa, where it may play an important role in peristalsis, it is also found to occur in high concentrations in the subcortical regions of the brain, especially the hypothalamus. Here, together with norepinephrine, it may be involved in neuronal systems that regulate those behavior mechanisms which can function without conscious control.

The functions of serotonin and norepinephrine in the brain are best understood against the framework of the concepts of Doctor W. R. Hess. About thirty years ago, Hess pointed out that the central autonomic nervous system does not operate independently, but is functionally integrated with the rest of the brain to maintain body integrity. He studied the nature of this integration by electrically stimulating various subcortical brain areas in unanesthetized cats. From the observed behavioral patterns, he postulated that physiologic responses to environmental changes are controlled by a subcortical system which co-ordinates autonomic, so-

*continued on next page*



matic, and psychic functions. He further postulated that this subcortical system consists of separate and antagonistic divisions, ergotrophic and trophotropic, which are normally in a state of dynamic balance.

The ergotrophic integrates sympathetic with somatomotor activities to produce behavioral patterns which prepare the organism for positive action: arousal, enhanced skeletal muscle tone and locomotor activity, elevation of blood pressure, increased sensitivity to sensory stimuli, hyperthermia, and others. NHI workers have implicated norepinephrine as the neurohormone of this integrative mechanism.

The opposing system, the trophotropic, integrates parasympathetic with somatomotor activities to produce behavioral patterns which are recuperative or protective in nature: drowsiness and sleep, decreased skeletal muscle tone and locomotor activity, lowering of blood pressure, decreased sensitivity to sensory stimuli, hypotension, and others. NHI workers have implicated serotonin as the neurohormone of this integrative mechanism.

The development of these conceptions by NHI workers has clarified the actions of drugs which influence brain function, many of which interact with serotonin or norepinephrine receptor sites.

One of these drugs, reserpine, was isolated when medical interest was revived in an old drug of the Indian pharmacopeia, *Rauwolfia*, whose beneficial effects in cases of hypertension and excited mental states seemed almost unbelievable. Perhaps the reason that it had been passed up was that we had been thinking for so long in terms of a specific drug for a specific effect that we completely ignored a drug whose effects were so varied.

In fact, reserpine elicits a bewildering array of apparently unrelated effects, but these are no longer unrelated when they are recognized as being identical to those of trophotropic predominance. In other words, reserpine stimulates one of the giant divisions of the subcortical integrating mechanism.

We now know that *Rauwolfia* compounds such as reserpine owe their effectiveness to their ability to release serotonin from its "bound" state in the brain to a "free" state. It does this by blocking the ability of the brain cells to store serotonin while not interfering with its synthesis. The blocking or destruction of these storage sites also explains the finding that, even though all measurable amounts of reserpine have vanished from the brains of rabbits within two to four hours, the tranquilizing effects persist for forty-eight hours. It is this effect on brain serotonin which accounts for the tranquilizing effects of reserpine. However, it has also been found that reserpine administered in doses that barely affect brain serotonin depletes norepinephrine stores at the peripheral nerve endings. This

"chemical sympathectomy" is important, since sympathetic nerve impulses cannot influence effector organs when no neurohormone is available at the peripheral nerve endings. Since the hypotensive effects of reserpine are primarily due to this ability to liberate peripheral norepinephrine, non-sedative doses are effective in the treatment of hypertension.

But sometimes this drug gets out of hand, producing extreme and dangerous depression. For this reason, Heart Institute workers have collaborated with industry in the study of a reserpine analog which releases norepinephrine peripherally, but does not release serotonin centrally. This compound is proving of value as a non-sedative hypotensive agent.

A drug that has the same general effects as reserpine, but which acts in a totally different way, is chlorpromazine. Chlorpromazine releases neither serotonin nor norepinephrine, but achieves the same effect as reserpine, not by stimulating the trophotropic, but by depressing the opposing trophotropic through the inhibition of the action of norepinephrine. This difference in mode of action may be illustrated with dopa, a precursor of norepinephrine which enters the brain and forms dopamine and norepinephrine. The stimulatory and increased sympathetic effects induced by dopa are dramatically blocked by chlorpromazine, but not by reserpine.

Lysergic acid diethylamine (LSD) is a drug of interest to those of us who have long believed that it is high time we were learning more about the chemistry of the brain instead of worrying about behavioral symptoms. A chemist working with LSD in Switzerland discovered that he suffered mental disturbances similar in a number of respects to those of the schizoid syndrome whenever he was exposed to this chemical in the laboratory. It was at first proposed that LSD produced its effects by antagonizing the action of serotonin at its active sites. However, it is now believed that LSD, mescaline, amphetamine, and other phenylethylamine congeners of norepinephrine mimic the action of norepinephrine in the brain and stimulate the ergotrophic system. In accordance with this view, these compounds elicit a wide variety of symptoms identical with those of ergotrophic predominance. Thus LSD and other ergotrophic agents stimulate the same system in the brain that chlorpromazine depresses, which accounts for the fact that LSD and chlorpromazine give virtually opposite responses.

The fact that LSD and other compounds which simulate the action of norepinephrine in the brain can produce effects akin to certain forms of mental illness might lead to the conclusion that mental illness is due to an unbalance in brain norepinephrine and serotonin. However, I feel that this would be an oversimplification. It must be remembered that



these affect only the lower part of the brain stem and not those higher centers of the thought processes, judgment, discrimination, and the like.

Since excessive amounts of serotonin and norepinephrine can have potent effects, there is, as might be expected, an enzyme that promptly destroys the free amines released at nerve endings. It is very important that this enzyme, monoamine oxidase, be present to prevent our being over-stimulated or over-depressed. Recent research on drugs which inhibit this enzyme, however, is leading to the development of drugs which might be useful against hypertension, angina pectoris, epilepsy, and mental illness.

The story of the monoamine oxidase inhibitors is a fascinating one. One of the first of these compounds was iproniazid, developed originally as a therapeutic for tuberculosis. However, when the drug was tested on patients in TB hospitals, it was found to excite them too much and its use had to be discontinued. But other workers found iproniazid very effective in certain types of depressed patients in mental hospitals. Studies have shown that iproniazid elevates brain levels of serotonin and norepinephrine, and incomplete studies suggest that the stimulating effects of this drug may be due to an increase in brain epinephrine. In any case, from this action came the rather peculiar term "psychic energizer."

A recent, more powerful monoamine oxidase inhibitor was JB 516 (1-phenyl-2-hydrazinopropane), synthesized by Doctor John Biel of Lakeside Laboratories. Workers at the Heart Institute became interested in this drug in connection with studies on hypertension as well as other effects of JB 516.

JB 516 has been found to lower blood pressure in hypertensive patients without producing some of the undesirable side effects of ganglionic blocking agents, e.g., constipation, dry mouth, mydriasis, and sexual impotence. Animal studies have also proved JB 516 effective in blocking the convulsions produced by electric shock or metrazol. These studies suggest that JB 516 may be effective against the convulsions of epilepsy, and may be a lead in finding the causes of this disease.

One of the side effects of JB 516, however, is one of the strangest and most fascinating of them all. Color blindness has always been used as one of the classic examples of a purely hereditary trait. However, it has been found that a number of patients receiving high chronic doses of JB 516 may develop red and green color blindness. This side effect vanishes when the therapy is discontinued.

This would suggest that the vistas opened up by the study of the chemistry of the brain are even vaster than we had believed. Just where this trail

that we are now following toward a better understanding of how our minds, our brains, and our senses work might ultimately lead, I can only guess. But I can assure you that it will be an exciting trail to follow.

### Discussion

(Following his address, Doctor Watt answered the following questions:)

*Q.* I am red and green color blind. Is the work you have just discussed likely to give us some insight into the physiology and psychology of color blindness?

*A.* I don't know about that, but the possibilities are certainly intriguing. The fact that JB 516 can produce color blindness may indicate that color blindness might be due to a change in the chemistry of the visual system—a change that might be modifiable in the right direction by another drug. For example, we know that the sickle cell trait is due to one misplaced amino acid in a very complex protein. An analogous chemical change may account for color blindness.

*Q.* We know that both chlorpromazine and Rauwolfia administered in large doses may produce pseudo-Parkinsonism. Do we have any understanding of the chemistry by which this occurs?

*A.* We may be dealing with something like this. Acetylcholine is a neurohormone of the parasympathetic system which transmits impulses across the peripheral nerve endings when present in normal amounts. However, excessive amounts of this neurohormone depolarize the membranes of the nerve cells and block these impulses.

The same may be true with serotonin. For example, low doses of 5-hydroxytryptophan, a serotonin precursor analogous to dopa in the case of norepinephrine, result in increased "free" serotonin and sedative effects. However, higher doses elicit signs of excitement. This reversal of effects is believed to be due to a blockade of the normal effects of serotonin by the high concentration of the free amine. Of course, Parkinsonism itself is a complex of things, and I am not sure that these drugs produce all the symptomatic effects.

*Q.* You stated that chlorpromazine blocks the sympathetic effect. Are there other drugs besides the monoamine oxidase inhibitors that increase the sympathetic effect?

*A.* Ritalin (methylphenidylacetate) and Mera-tran (pipradol) are two drugs analogous to LSD which exert a central action on the sympathetic system. Both have been effective in treating depressed patients.

*Q.* May I ask about the poisonous mushroom investigations carried out by Watson?

*concluded on page 174*

## GLUCOSAMINE-POTENTIATED TETRACYCLINE IN PEDIATRICS

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THE ABILITY of glucosamine (2-amino-D-glucose) to potentiate absorption of tetracycline from the gastrointestinal tract was first demonstrated in 1958 by Carlozzi, who showed that "a combination of tetracycline plus glucosamine gave the highest antimicrobial levels of the four (tetracycline) preparations tested, being followed in order by tetracycline plus citric acid, tetracycline plus sodium hexametaphosphate, and tetracycline phosphate complex."<sup>1</sup> Further confirmation of the increase in serum levels of tetracycline activity by glucosamine was presented in studies conducted at the Division of Antibiotics of the Food and Drug Administration,<sup>2</sup> as well as in studies by Snell and his colleagues employing radioactive isotopes.<sup>3,4</sup>

In clinical studies, the tetracycline-glucosamine combination has been found to exhibit a wide range of antimicrobial activity comparable to unpotentiated tetracycline, oxytetracycline, or chlortetracycline. Reports indicate, however, that glucosamine-potentiated tetracycline is more rapidly absorbed than unpotentiated tetracycline, and that it produces higher serum levels which are satisfactorily maintained with the usual clinical dosages.<sup>5-9</sup> Equally as important, particularly in treating children, the tetracycline-glucosamine combination appears to be well-tolerated.

It is especially important that a drug used in pediatric practice should not cause gastrointestinal upsets. The variations in anatomic, physiologic, pathologic, and immunologic patterns that produce different clinical manifestations of disease in children than in adults, may also cause differences in type or extent of response or untoward effects to therapy. For example, diarrhea which often is a minor side effect of oral antibiotic therapy in adults can be a major side effect in children. Physiologically, the relatively greater nutritional needs of

infants increase the impact of gastrointestinal upsets. The infant with a diarrheal disturbance is in a more precarious position than the adult because of the greater rapidity with which he develops severe states of anhydremia and acid-base disturbances.<sup>10</sup>

In a report on the use of glucosamine-potentiated tetracycline in the treatment of upper respiratory infections in 50 children, Nathan<sup>7</sup> noted that the preparation was extremely well-tolerated. "Side effects were mild and transitory. The infrequent occurrence of loose stools in eleven patients did not necessitate interruption of therapy."<sup>7</sup> Nathan's finding is supported by the results of this investigation of the clinical effect and incidence and severity of side effects in infants and children of the tetracycline-glucosamine preparation.

#### Materials and Methods

In all, 150 children between one month and fourteen years' old were treated in the office, the home or on the ward for various infections including tonsillitis, bronchitis, pharyngitis, bronchopneumonia, and otitis media (table). Fifteen children were patients at the Rhode Island State Infirmary for chronic mentally ill children, thirty-one were inpatients at St. Joseph's Hospital, Providence, Rhode Island, and the remaining 104 children were treated in office and house calls in private practice.

Tetracycline with glucosamine was administered either in capsules (125 or 250 mg. of tetracycline per capsule), oral suspension (125 mg. tsp.), or pediatric drops (5 mg. drop).<sup>\*</sup> The average daily dose was 25 mg. kg. of body weight administered in divided doses. The tetracycline-glucosamine preparation was administered while the patient was febrile and for three or more days after the patient was afebrile.

Patient responses to therapy were classed as "excellent" if the child had a major clinical improvement and had become afebrile within 72 hours. Responses were classed as "good" if clinical improvement was slower and the patient had become afebrile within 120 hours. Lesser responses were classed as "fair." A "poor" classification was given if the patient failed to respond or if side effects

<sup>\*</sup>Cosa-Tetracyclin Capsules, Cosa-Tetracyclin Oral Suspension, Cosa-Tetracyclin Pediatric Drops (orange-flavored), Pfizer Laboratories, Brooklyn, New York.



occurred regardless of the patient's clinical improvement.

### Results

The clinical responses to the glucosamine-potentiated tetracycline were uniformly satisfactory. In some instances they were markedly superior to previous results with penicillin, erythromycin, or other antibiotic agents.

Eighty patients (53.4% of the group) had excellent responses—20 becoming afebrile within 24 hours. Thirty-four patients (22.6%) had good responses becoming afebrile within 120 hours. Twenty-two patients had fair responses requiring 6 to 10 days of therapy before they became afebrile. No patient failed to respond to therapy and no patient developed side effects.

### Case Histories

Patient 1, a twenty-five-month-old boy, institutionalized for severe mental retardation resulting from porencephalic cyst, received antibiotic therapy for an acute upper respiratory infection with cough and temperature of 103.4 degrees of two days' duration. Before therapy, nose and throat cultures and X rays were negative. His leukocyte count was 26,400 and hemoglobin 99 per cent. His weight was 19½ pounds. At the age of 1 day, he had had a large portion of his bowel removed. As a result, he customarily had two to three large, loose bowel movements a day.

The child was placed on the tetracycline-glucosamine preparation, 125 mg. every six hours. His temperature was normal in 24 hours, however, he was continued on therapy for seven days. On the second day of therapy he had six instead of three loose movements. No change was made in the regimen, and his bowel movements returned to pretreatment amounts. After one week of therapy, the child's final leukocyte count was 8,100, hemoglobin 88%, and weight 19¾ pounds.

Patient 2, an eleven-month-old boy with cerebral atrophy was treated for rhinitis and for multiple boils on his face, trunk, and extremities. He was not acutely ill, but he had failed to respond to therapy with penicillin. Laboratory studies showed a leukocyte count of 12,000 (neutrophils 43%, lymphocytes 39%, monocytes 15%, eosinophils 3%) and hemoglobin 12.0 Gm./100 ml. His weight was 17.3 pounds. Nose and throat cultures showed the major pathogenic organism to be a coagulase-positive hemolytic micrococcus pyogenes aureus. The organism was susceptible to novobiocin, erythromycin, oleandomycin, bacitracin, chlortetracycline, tetracycline, and oxytetracycline. It was not susceptible to penicillin. Although the test showed the organism to be susceptible to erythromycin, the patient did not respond to a course of therapy with that antibiotic.

The child was placed on 125 mg. of glucosamine-potentiated tetracycline every four hours. His rhinitis subsided within 24 hours and his boils subsided in six days. The medication was continued for 13 days without side effects.

Patient 3, a twelve-year-old girl with cerebral agenesis, was shown by X-ray examination to have bronchopneumonia in the left lower lobe. Initial throat cultures revealed a hemolytic streptococcus to be the predominant organism. Her leukocyte count was 10,700 (neutrophils 72%, lymphocytes 22%, monocytes 6%) and her temperature 101.8 degrees.

Therapy with penicillin was unsuccessful. Erythromycin therapy also failed to produce a favorable response. The tetracycline-glucosamine preparation was administered as an oral suspension, 1½ tsp. (200 mg.) every six hours. The patient was afebrile after four days and well in seven days. She showed no side effects.

### Discussion

About 75 per cent of the medical care of children and about one third of the general practitioner's time is devoted to pediatrics,<sup>10</sup> and in no other part of the physician's work is the old adage "an ounce of prevention is worth a pound of cure," so applicable.<sup>10</sup> The use of chemotherapeutic agents for prophylaxis of infections should be undertaken judiciously and with a knowledge of potential hazards. The agent or combination of agents should be selected on the basis of the potential infection under attack.<sup>11</sup> Naturally, antibiotic support should not be withheld in severe infections until bacteriologic studies have been completed.

In this evaluation, particularly among the hospitalized mentally retarded children, the tetracycline-glucosamine preparation was administered under difficult conditions. The infections encountered were, in most instances, highly contagious and the patients were in constant contact with each other. Under such conditions, sore throats, boils and other infections can sweep through an infirmary. Nevertheless, therapy was quite successful in preventing the spread of infection. With the appropriate use of the tetracycline-glucosamine preparation we were able to keep cross-infections and the incidence of infection at the infirmary at a bare, almost irreducible minimum.

It must be noted, however, that despite the usefulness of the preparation in returning the children to a noninfectious state, throat cultures obtained following the completion of therapy revealed a persistence of micrococcal organisms. Perhaps the organisms in these instances were nonpathogenic; but they nevertheless persisted and one could not say that the tetracycline preparation actively decreased micrococci.

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The results of this study do show, however, that a busy general practitioner can use the tetracycline-glucosamine preparation in patients with febrile respiratory illness and expect to render a cure in two to five days in over 85% of the patients.

The lack of gastrointestinal distress, and particularly of diarrhea, as a side-effect of therapy with tetracycline-glucosamine combination may be due to the presence of the glucosamine. Sauvage<sup>12</sup> has reported that glucosamine may well alter the course of diarrhea in infants and children. In a controlled study, Sauvage found "that the response and return to an afebrile, asymptomatic state was prompt with those patients (with diarrhea) on glucosamine as compared with those not receiving the amino sugar. The average duration of diarrhea for the group on glucosamine was 34 hours and for the group not receiving glucosamine, 78 hours."<sup>12</sup> The dosage of glucosamine used, however, (3 Gm. every 6 hours) was considerably larger than that contained in the tetracycline-glucosamine preparation (25 mg. kg. of body weight daily).

## SUMMARY AND CONCLUSION

A total of 150 patients aged one month to fourteen years were treated with glucosamine-potentiated tetracycline for various pediatric infections. Eighty of the children became afebrile within 72 hours and all but 22 within five days. All of the children responded to therapy within 10 days. There were no side effects to therapy. The glucosamine-tetracycline preparation showed a prompt antibacterial action and a broad range of antibacterial effectiveness with a remarkably low degree of toxicity.

## INDICATIONS FOR THERAPY WITH GLUCOSAMINE-POTENTIATED TETRACYCLINE

Indication	Number of Cases*
Tonsilitis	60
Bronchitis	25
Pharyngitis	23
Bronchopneumonia	12
Otitis media	12
Upper respiratory diseases	19
Miscellaneous infections including: gastroenteritis, encephalitis, boils, gingivostomatitis, roseola, abscess, cellulitis, pyelitis, and others	28

\*29 patients had multiple infections.

## REFERENCES

- Carlozzi, M.: Evaluation of antibiotic blood level enhancement factors. *Antibiotic M.* 5:146-151 (1958)
- Welch, H.; Wright, W. W., and Staffa, A. W.: The effect of glucosamine on the absorption of tetracycline and oxytetracycline administered orally. *Antibiotic M.* 5:52-58 (1958)
- Snell, J. F.; Garkuscha, R., and Allen, E. L.: Radioactive oxytetracycline, II. Distribution in C-57 BL mice (preliminary experiment). *Antibiotics Annual, 1957-1958*, New York, Medical Encyclopedia, Inc., 1958, pp. 502-506.
- Snell, F., and Garkuscha, R.: Radioactive oxytetracycline (Terramycin). III. Effect of glucosamine HCl on serum concentrations. *Proc. Soc. Exp. Biol., N.Y.* 98:148-150 (1958)
- Cornbleet, T.; Chesrow, E., and Barsky, S.: Use of tetracycline with glucosamine in dermatology. *Antibiotic M.* 5:328-329 (1958)
- Harris, H.: Tetracycline with glucosamine in the treatment of acne. *Clinical Review.* 1:15-17 (1958)
- Nathan, L. A.: Use of glucosamine-potentiated tetracycline in the treatment of upper respiratory infections in children. *Arch. Pediat.* 75:251-255 (1958)
- Shalowitz, M.: Treatment of upper respiratory infections with Cosa-Tetracyn. *Clinical Review.* 1:25-26 (1958)
- Stone, J. L.; Bamford, J., and Bradley, W.: Treatment of gynecological infections with glucosamine-potentiated tetracycline. *Antibiotic M.* 5:322-325 (1958)
- Nelson, W. E.: An introduction to the medical problems of infants and children. *Mitchell-Nelson Textbook of Pediatrics*, ed. W. E. Nelson, W. B. Saunders Co., Philadelphia, 1950, pp. 1 ff
- Poncher, H. G., and Unna, K. R. W.: Drug therapy. *Mitchell-Nelson Textbook of Pediatrics*, ed. W. E. Nelson, W. B. Saunders Co., Philadelphia, 1950, pp. 232 ff
- Sauvage, R. D.: Use of glucosamine in an outbreak of diarrhea in children. *Clinical Review.* 1:24 (1958)

## THE PHARMACOLOGICAL REVOLUTION

*concluded from page 171*

A. One of the drugs that have been obtained from mushrooms is bufotenine (n-methyl serotonin), an analog of serotonin having somewhat the same kind of effect. There are a number of colloidal substances in mushrooms which have not been fully investigated, and within a year there may be more to add to bufotenine. Natural products versus chemical syntheses make an interesting competition. The screening problems encountered in synthesizing compounds are somewhat offset by the problems of isolating and purifying the natural product.

Q. Some of these drugs which you have discussed are being widely used for the treatment of depressed states. Do you consider them actually dangerous? Are you afraid of them?

A. Yes, I am. Or perhaps it would be better to say that I have a healthy respect for all of them. In the old days, we could afford a shotgun approach to drug therapy because we were dealing with crude extracts and impure mixtures whose effects were relatively impotent. However, as we approach closer and closer to these purified substances, their potency increases. This places an increased responsibility upon the physician, who must, with much greater precision, know his patient. The very ability to hit a target hard means that we must be sure that we have chosen the correct target. Increasingly, we cannot afford to say, "Let's try this drug. It may do some good and it will not do any harm." I feel that most potent drugs almost surely do harm, and thus there should be a positive reason for using them.

## FREE CHOICE OF PHYSICIAN AND CLOSED PANEL SYSTEMS

### Abstracted from the Report of the Commission on Medical Care Plans of the American Medical Association

At the Clinical Session of the A.M.A. held in Minneapolis last December, the report of the Commission on Medical Care Plans was considered. The report was received without discussion and act was deferred until the June, 1959, meeting of the House of Delegates at Atlantic City. The House, however, voted to ask the Constituent Associations to review the report and transmit their decisions with regard to the following basic points:

#### 1. *Free Choice of Physician*

Acknowledging the importance of free choice of physician, is this concept to be considered a fundamental principle, incontrovertible, unalterable, and essential to good medical care without qualification?

#### 2. *Closed Panel Systems*

What is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician?

Below are reprinted sections of the report relating to these two basic issues, together with conclusions of the Committee. Every member of the Rhode Island Medical Society should read these presentations (the entire report is available at the Medical Library) and make known his views to the delegates of his district to the Rhode Island Medical Society.

### III. FREE CHOICE OF PHYSICIAN

THE MEDICAL PROFESSION exists to serve the physical and mental needs of all humanity. The tools of the physicians are life-long study, intelligent use of scientific equipment, and dedicated service.

The medical profession also has long had the objective of rendering good medical care at a cost the people can afford to pay.

There are many factors in the attainment of this goal. One of these is the freedom of choice of physician which has been, and still is, a fundamental principle of medical practice.

The twentieth century has seen basic freedoms of mankind restricted or even abolished in many lands. The physicians of the United States believe that it is their duty to preserve fundamental freedoms to prevent the deterioration of medical care which has resulted in many areas because of restrictions on the forms of medical practice.†

"Freedom of choice" means the right of the individual to exercise, without restraint, selection among alternatives. Furthermore, as applied to medical care, an individual should have the right to select a physician of his choice. The medical profession subscribes to, supports, and strives to attain complete acceptance and application of this principle of "freedom of choice."

The medical profession is aware, however, that

the principle has been restricted in its application in some situations. Among such instances are the following: by action of law; by social and economic changes leading to new methods of financing the cost of medical care; by action of the profession in establishing systems of staff appointments granting limited privileges; by the rating of physicians for the performance of various types of medical care; by the certification of specialists; by action of hospitals as recognized in the 1947 Report of the Judicial Council which, in part, stated that,

In order that a high standard of service be maintained, hospitals may limit somewhat the number of physicians who deliver medical services in their institutions and even assign a physician to certain definite fields in accordance with his training and experience.

Another example is the reaffirmation by the House of Delegates in December, 1957 of the 1927 Report of the Judicial Council which stated that a contract would be considered unfair and unethical,

... when a *reasonable degree* of free choice of physician is denied those cared for in a community where other competent physicians are readily available. . . . (Emphasis added.)

In December, 1955 the House of Delegates adopted the following in its statement on "Medical Relations in Workmen's Compensation."

Disabled employees should have the right to accept physicians' services provided by employers, or to select another attending physician from a register of all other physicians in the community willing and *qualified* to perform the essential service. (Emphasis added.)

Other examples of apparent conflict between principle and its application are the following: Chapter I, Section 2, page 5 of the Principles of

*continued on next page*

†Dr. Price comments: To balance the statement, I should like to point out that the twentieth century has also been marked by new freedoms, new opportunities for social and scientific experimentation, improved social status, and better living standards. This is particularly true with regard to medical care made available through vast funds resulting from collective bargaining which seeks to secure more medical care for large industrial groups.



Medical Ethics of the A.M.A. (December, 1955) which is contained in the "Guides for Evaluation of Management and Union Health Centers" states, in part, that, "Physicians . . . must dispense the benefits of their special attainments in medicine to all who need them." Elsewhere, however, in the Principles of Medical Ethics (Section 5) it is stated that, ". . . a physician may choose whom he will serve"—in which case the patient may be denied his choice. In upholding the concept of "free choice of physician" it has been stated that,

Every physician duly licensed by the state to practice medicine and surgery should be assumed at the outset to be competent in the field in which he claims to be, unless considered otherwise by his peers. (*Suggested Guides to Relationships between State and County Medical Societies and the United Mine Workers of America Welfare and Retirement Fund*, adopted by the House of Delegates, December 1957.)

The latter statement has led to controversy since physicians in a community may be reluctant to state frankly their opinion as to another's qualifications and yet the judgment of concerned physicians elsewhere might not be acceptable.

These historical developments have acknowledged that choice of physician is for some people not free in the literal sense of the word. Nevertheless, numerous resolutions adopted by the House of Delegates have continued to reiterate the conviction that "free choice of physician" by the patient is essential to the provision of medical care of good quality. Some have been confused because they have failed to distinguish between acceptance of the principle and restrictions on its application. The foregoing statements of policy are the result of earnest efforts to resolve conflicts between the idealism which is an important element in making the practice of medicine a profession and the practicalities of this modern social and economic era. As citizens, physicians have the obligation to resist trends which they believe are detrimental to the best interests of society. As physicians, our additional function is to provide care of good quality to people at a cost they can afford. Since free choice of physician has been denied in some mechanisms for the provision of medical care, it is incumbent upon the profession to understand the reasons for this action and to be aware of its effects upon the quality of medical care.

In the closed-panel, direct service, type of plan visited, the committee has uniformly observed care of good quality being made available to patients who do not have "free choice of physician" in the literal sense of the term. This is possible when sponsors of these plans have accepted their obligation to see that plan physicians are well qualified. Financial arrangements exist which make possible the prediction and budgeting for the cost of providing service. Based on its observations, the committee

finds that the absence of "free choice of physician" does not necessarily result in inferior care; but the committee in no way intends to state that good quality medical care was rendered in these plans because of the absence of free choice.††

The committee has noted a trend toward offering the individual employee more than one plan for medical care so that he may exercise his choice. The committee believes that this development is commendable. It indicates that proponents of some closed panel plans have come to recognize the desirability of a wider choice of physician by the patient.

"Free choice of physician" is an important factor in the provision of good medical care. In order that the principle of "free choice of physician" be maintained and be fully implemented the medical profession must discharge more vigorously its self-imposed responsibility for assuring the competency of physicians' services and their provision at a cost which people can afford.

Attention is called to Section 4 of the Principles of Medical Ethics, adopted June, 1957 which states,

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.†††

In summary, the medical profession is determined to maintain the highest possible standards of medical care. Freedom of choice is an important factor in the achievement of this goal.

††Dr. Leo Price comments: The last part of this sentence is gratuitous. In my opinion, this is not the issue. It tends to divert attention from the fundamental issue, which is the provision of good quality medical care despite the presence of social or economic barriers. Good quality medical care can be provided by physicians, regardless of the framework within which medicine is practiced. The physician who has a deep interest in humanity often makes great personal sacrifices to live up to the Hippocratic Oath to provide care to the sick and needy. Such dedication is most likely to be nurtured in an atmosphere where freedom to practice medicine without interference is guaranteed—regardless of whether "open" or "closed" panels are involved.

†††Dr. James R. Reuling comments: "Free choice" must always stand as a principle, and we should never give up fighting for principles. However, it is going to become only a hollow phrase unless the county societies throughout this country vigorously, and without fear or favor, clean their own house in accordance with Section 4 of the Principles of Medical Ethics.

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*Be at the Annual Meeting*

**May 12 and 13**

**Rhode Island Medical Society**

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#### IV. THIRD PARTY RELATIONSHIPS IN MISCELLANEOUS AND UNCLASSIFIED PLANS

THIS SECTION is concerned with the relationships which should exist among plan members, and physicians, and the many types of medical care plans, particularly closed panel plans, which the committee has studied.

As Part II of the Commission's report discloses, the medical profession has dealt for many years with various organizations which assist individuals in paying for medical care or which arrange for the provision of medical care. Due to many social, economic, and legal factors the number of, and enrollment in, these organizations has increased. They are often referred to as third parties, and are here defined as mechanisms which, for any reason, enter into the relationship between the patient and his physician. Such an all-inclusive definition is necessary because third parties assume such a wide variety of forms and activities.

Among the third parties are the Miscellaneous and Unclassified plans studied by the committee. Any consideration of the relationships that should exist among these plans, and patients, and physicians, must be predicated on recognition of the following:

1. Some of these mechanisms have been associated with medical practice for many years.
2. Many of them are likely to remain in the field of medical care and become increasingly important to patients and physicians.
3. In many states closed panel plans can be legally organized and operated as a result of legislation and court decisions.
4. The development and operation of these plans have been encouraged, in part, as the outcome of collective bargaining between unions and employers.
5. Many of these programs are claimed to be an economic necessity for many persons whom they serve.
6. The stated objectives of these plans are the arrangement for payment and/or the provision of a greater amount of good medical care at a cost that can be afforded.

Problems have arisen between these plans and the medical profession. Some of them have been resolved but others have persisted and new problems continue to arise.

Many third party mechanisms in the group of Miscellaneous and Unclassified plans have interfered with free choice of physician by establishing closed panels of physicians. Some of them have caused adverse physician reaction by adopting a

method of compensation other than the usual fee for service. Some of the plans have established their own professional standards which limit the activities of plan physicians and exclude some physicians from participating in the plan. A great many physicians believe that the development of closed panel plans is a threat to private practice. Some physicians object to these plans because they change the traditional form of medical practice. Some physicians contend that many of these plans, through administrators, or governing boards, or both, interfere with the patient-physician relationship; some, that plan members cannot secure good quality medical care, and some, that closed panel practice has the potential to affect adversely the quality of medical care. It is contended that the personal freedom in the practice of medicine might be adversely affected if all physicians should ultimately be obliged to associate themselves with these plans in order to practice medicine. It is contended by many physicians that some of these plans utilize promotional methods and exercise such absolute economic controls as to create a monopolistic effect.<sup>†</sup>

These contentions have been subjects of controversy between segments of the medical profession and various plans. Notwithstanding these disputes, other physicians appear to be satisfied with their relationships with a closed panel type of practice as well as with other types of third party mechanisms.

In order to resolve existing disputes and to avoid conflict, there are certain basic concepts which should guide the relationships among plan members, and physicians, and these plans. The recognition of these concepts would provide a basis for mutual understanding and co-operation and aid in the achievement of a mutual objective of both the medical profession and these third parties—the provision of good medical care at a cost which can be afforded. The most important of these concepts, relating to plan members, physicians, and these plans, are set forth below.

##### PLAN MEMBERS

Medical care of good quality should be available to plan members at a cost which will not be a deter-

<sup>†</sup>Dr. Leo Price comments: Monopoly in any form can only be objectionable if it possesses characteristics which are inimical to the best interests of society. This is true regardless of whether management, labor, a professional society, or any other organized body promotes it. The reference to "monopolistic effect" might therefore be equally applicable to Blue Shield Plans in those states which have passed special enabling legislation to give this organization the sole legal authority to offer prepaid medical care to the public.

rent to the procurement of such care. They should be routinely informed of the amounts of the contributions of the employer and employee which are expended for such services. Mechanisms should be established to hear and resolve complaints of patients concerning the plan of which they are members. Patients should have the widest possible choice of physicians from among those serving in a closed panel or from among other physicians in the community who are willing and competent to render the service. In the latter instance, it is essential that there be 1) a mutually acceptable determination of fees which a closed panel can pay and the willingness of physicians to provide services for those fees, and 2) the assurance of competency as set forth in subsequent paragraphs and in Section III on "Free Choice of Physician."

Plan members should become familiar with the scope of services afforded by a plan to the end that they will be used reasonably and effectively.

### PHYSICIANS

Physicians are entitled to practice medicine without lay interference in decisions on predominantly professional matters. Those affiliated with plans should have working conditions and remuneration which will assure the provision of good medical care. They may accept remuneration from any plan on any basis which is not in violation of the Principles of Medical Ethics. The medical profession may reasonably expect that plans should and will co-operate with it in seeking consultation and guidance in the attainment of good medical care.

Physicians who provide services under the plan should render competent medical care to members of plans at a cost which will not be a deterrent to the procurement of good medical care. They should use reasonable efforts to prevent unnecessary utilization of plan services and facilities. The medical profession has a dual responsibility of assuring the competence of its members and of disciplining them when evidence of incompetence or abuse of plan benefits are present. Physicians have the obligation of offering guidance and consultation to third parties to improve the quality of medical care, and of maintaining active liaison mechanisms to resolve problems and controversies which may arise.

### THE THIRD PARTY IN MISCELLANEOUS AND UNCLASSIFIED PLANS

Under proper legal authority, these third parties are privileged to develop medical care plans. They may reasonably expect that competent medical care will be rendered by all physicians who provide services under the plan to their plan members at a cost that will not be a deterrent to the procurement of such care. They may justly expect that their plan will not be subject to unnecessary utilization by their plan members. Their obligation to expend funds efficiently should be recognized. They are entitled to the co-operation of the medical profession in developing and maintaining relationships which are ethical.

These third parties should hold administrative expenses to an acceptable minimum so that the highest possible percentage of their income is spent for medical care. They should make clearly known to beneficiaries the nature and extent of services or benefits which are available. The cost to members for plan participation should be made known to them by the plan. They should provide the beneficiary with the widest possible choice of physicians as stated in the paragraph entitled "Plan Members." They should refrain from interfering in patient-physician relationships and should prevent lay interference in the practice of medicine. When plans contemplate entering a community, they should give consideration to the effect a closed panel plan might have on the practice of physicians who are located there and on the effect of medical care available for the community, particularly that segment which is not affiliated with the plan. Every effort should be made by the third party to minimize any adverse effects. These third parties should seek the counsel and guidance of the medical profession in the initiation, development, and operation of plans. The co-operation of the profession should be enlisted in resolving problems and controversies which may arise.

The foregoing represent the bases upon which conclusions and recommendations have been formulated with respect to the third party in the group of Miscellaneous and Unclassified plans and its relationships with plan members and physicians. These appear in the following sections of this report.

## SUMMARY OF SOME OF THE CONCLUSIONS IN THE STATEMENT OF THE COMMITTEE CONCERNING LAWS RELATING TO MISCELLANEOUS TYPE PLANS

1. As applied to the miscellaneous plans, the term "corporate practice of medicine" has been used in many different ways to describe not only prepaid

plans but other arrangements by which medical service is made available to various groups by different corporations, such as corporations or-

*continued on page 184*

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## NEW STANDARDS FOR FOREIGN DOCTORS

AT A RECENT SEMINAR on medical education held at Beverly Hospital on January 9 and 10, Doctor Dean F. Smiley, executive director of the Educational Council for Foreign Medical Graduates, presented a summary of the work of his organization to date, which is of interest to all physicians who are concerned with the care of patients in community hospitals. Doctor Smiley gave a short summary of the formation of the Council by the combined efforts of the American Medical Association, the Association of American Medical Colleges, the American Hospital Association and the Federation of State Medical Boards. He stated that the main activities of the organization are (1) the furnishing of information to foreign graduates; (2) the checking of their credentials; (3) examining them in their knowledge of medicine; (4) carefully checking their use of the English language, and (5) certification of those who have been found qualified. The examination is given in basic English and every question has been checked very carefully by experts as to its value. There are 360 questions, all of the "multiple choice" type. A candidate's command of English is tested by requiring him to listen to a medical history read slowly and clearly by the proctor, to take notes as he listens, and then to write out the history as best he can. This is done just before the written examination.

Doctor Smiley reported that the first examination, which was given in March 1958 to candidates living in the United States, resulted successfully

for 51 per cent of the 298 foreign graduates who took it. Seventeen per cent "nearly passed" and will be encouraged to continue their work in this country and retake the examination in the next two years. The second examination held in September 1958 was given to 707 physicians in the United States and to 137 abroad. The overseas examinations were held in 28 countries. Of the 707 candidates with addresses in the U.S.A. 52.4 per cent passed and 27.3 per cent "nearly passed." Of the 137 examined in other countries 34.3 per cent passed and 24 per cent "nearly passed." (Nearly passing indicates a mark of 70-74 per cent.)

This work is of particular value to the community hospitals of the United States—especially to such as have found it impossible to secure graduates of American or Canadian medical schools for their house staffs. As Doctor Smiley stated, there are about 7,600 foreign medical graduates in this country on exchange or student visas, and over 1,000 who have come as permanent immigrants. At the present time the United States attracts more foreign physicians than any other country. The situation has not been a healthy one because the smaller community hospitals have been forced to accept foreign graduates without having a reliable method of appraising their qualifications, and at times have appointed physicians whose knowledge of medicine has turned out to be definitely substandard. That such hospitals have in a few instances been guilty of exploiting foreign physicians without giving them a real educational experience is unfortunately

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true, but at present this is very definitely being corrected by a nation-wide drive to improve the training programs of hospitals not affiliated with universities. It is understandable, of course, that the staffs of such hospitals can hardly be expected to show much enthusiasm for teaching house officers whose basic education has been poor. On the other hand, many highly capable foreign graduates—the equal of those trained in America—are among those who have arrived in recent years.

The value of the work of the Educational Council for Foreign Graduates to the hospitals is, of course, that it accurately selects physicians who have been trained abroad and thus protects the hospitals from otherwise inevitable mistakes in the recruitment of their house staffs. This means protection of the American public. Although it may be that for a year or two the supply of available physicians to fill internships and residencies in community hospitals may be reduced, eventually this should be corrected and the end result will be beneficial to all concerned.

### RES IPSA LOQUITUR

Medical malpractice suits are reported to be on the increase throughout the country. Some of the cited causes for suits, or threatened suits, indicate that the public, abetted by a segment of the legal profession, considers that every act of the physician in his treatment of illness speaks for itself, and proof of actual negligence in any case by expert testimony is not necessary.

The tendency today to sue a doctor on the slightest provocation is fraught with great disservice to the public at large. If the trend continues many physicians will simply cease to employ important clinical techniques regardless of their benefit to the patient and regardless of the fact that, statistically, serious complications are rare. The occupational risk becomes too great for the physician to assume if he is to be sued for astronomical amounts because the treatment is painful, or unsuccessful.

An English court has pointed up the issue well in its opinion that

"We should be doing a disservice to the community if we imposed liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors work. We must insist on due care for the patient, but we must not condemn as negligence that which is only misadventure. . . ."

The medical profession does not condone the negligent act, whether it is done by the physician

who exceeds his limitations, or by the experienced practitioner. It does protest the tendency to advance the theory that the act speaks for itself where an unfavorable complication may occur even in the presence of the highest degree of care.

If the practice of medicine is not to be curtailed there must be a halt on the inroads being made on the sound principles of the law protecting the medical profession from the evils of jury speculation and resultant liability without fault.

### FREE CHOICE AND THE CLOSED PANEL SYSTEM

At a time when the medical profession is deeply concerned with the intrusion of more and more "third" parties in the offering of medical care services to the public, the 96-page special edition accompanying the January 17 issue of *The Journal of the A.M.A.* is "must" reading for every doctor.

The work of three and one-half years of research on issues that involve every physician, the report of the Commission on Medical Care Plans focuses particular attention upon the question of free choice of doctor, and on closed panel systems. For the information of members of our Society who did not receive the special issue, or did not read it in its entirety, we reprint on page 175 of this issue what are undoubtedly the two basic points that must be resolved.

The entire report was given preliminary review at the Minneapolis session of the American Medical Association last December. The House of Delegates then voted to ask the state medical associations to review the report and send in their decisions two months prior to the Atlantic City meeting of the A.M.A. scheduled for next June.

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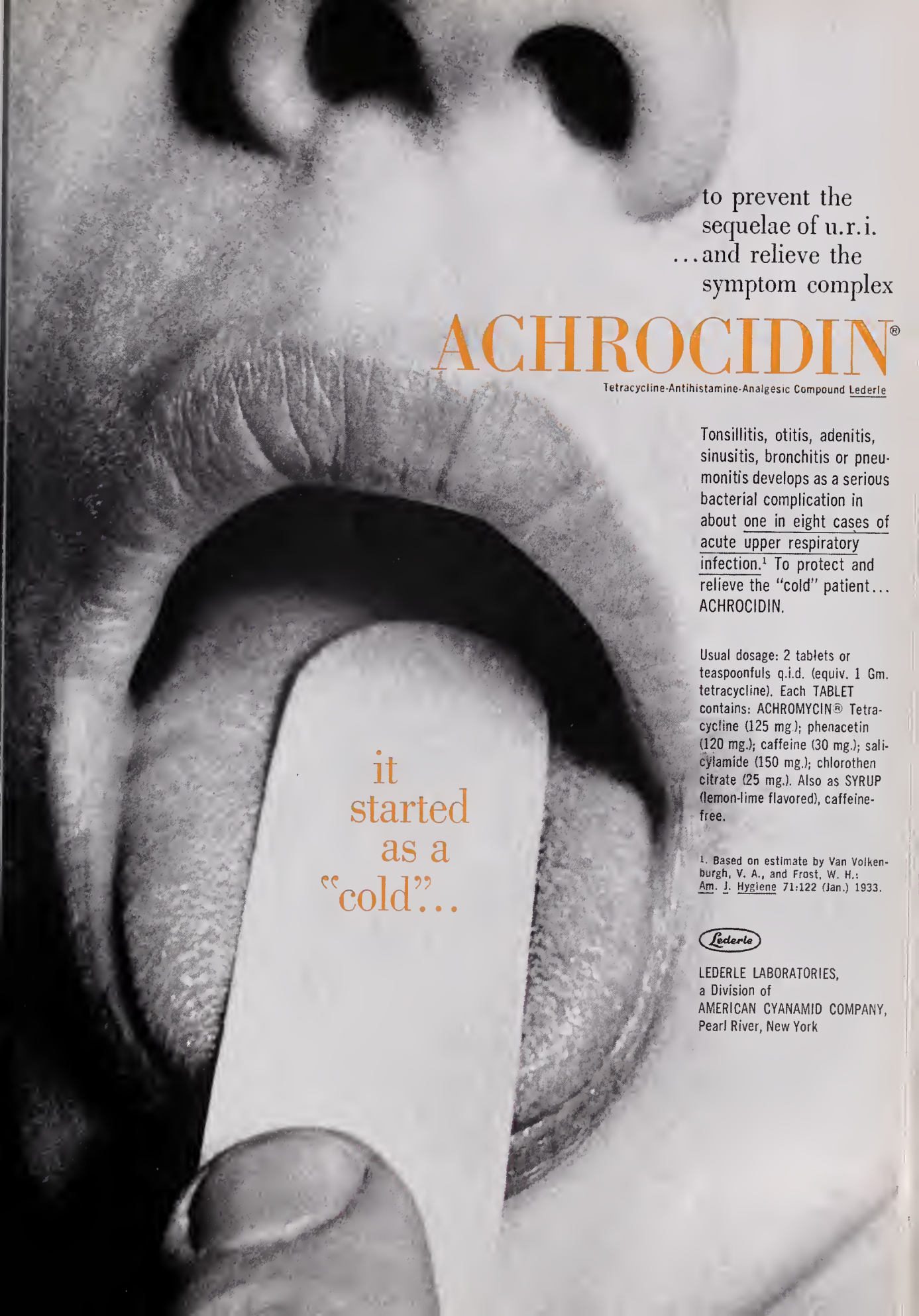
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it  
started  
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"cold"...

<sup>1</sup>. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933.



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Reinhardt, D. J.:  
Delaware State Med. J. 30:1, January 1958.

## RESULTS

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Bunn, W. H., Jr.:  
Ohio State Med. J. 54:1168, September 1958.

## MINIMAL SIDE EFFECTS

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Herrmann, G. R., Hejtmancik, M. R., Graham, R. N.  
and Marburger, R. C.:  
Texas State J. Med. 54:639, September 1958.

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# FREE CHOICE OF PHYSICIAN AND CLOSED PANEL SYSTEMS

*continued from page 178*

- ganized for profit or not for profit for that purpose, industrial organizations, fraternal groups, hospitals, co-operatives and health centers. The phrase has been used to describe arrangements in which the organization providing or agreeing to provide the service is not a corporation but, for example, a partnership, trust or association. The phrase "corporate practice of medicine" is a misnomer when used to describe a plan in which a corporation is not involved. Insofar as the phrase is used by some to imply that a particular arrangement or plan is universally illegal, it can be misleading.
2. The law applicable to the organization of miscellaneous plans varies from state to state. As a result of court decisions in some states, legislation and changes in social philosophy which have occurred in this country, miscellaneous prepaid plans, particularly closed-panel plans, can now be legally organized and operated in some states even though a corporation is involved and the plan engages in advertising. There is no constitutional provision or inexorable principle which prevents a state from authorizing a corporation, including a closed panel, to provide medical care. The question is one of state policy determined by the legislature or by the courts in construing state laws.
  3. State laws do not universally prohibit a corporation from utilizing a closed panel in the operation of a prepaid plan. Unquestionably, in the absence of permissive legislation this practice in some forms is barred in some states. It is clearly lawful in other states when conducted by not for profit corporations organized under general corporation statutes or enabling legislation. Between the two extremes, in other states, these closed-panel plans are lawful in varying degrees and forms. Similar variations are found with respect to internal structure and operation. Partnerships,
- trusts, unincorporated associations and other devices, rather than corporations, have been used in organizing these plans, in some instances to avoid challenge under court decisions.
4. The Taft-Hartley Act has influenced the legal form of some plans in that it permits payments to be made by employers through collective bargaining to trusts established by employee representatives for the purpose of providing, or buying insurance for, medical care for the benefit of employees and dependents. The law neither prohibits nor requires medical representation on the governing board of the trust.
  5. Although medical societies, like other associations, have considerable latitude with respect to membership, their control of membership is subject to important limitations. A major limitation occurs if the society's action concerning membership has an adverse effect on a business. Court decisions demonstrate that any medical society may be on dangerous ground if it denies membership to physicians, disciplines members, or threatens to do so because they render services for prepaid plans, including closed-panel plans. In certain circumstances such action might violate the Sherman Antitrust Act if interstate commerce is involved, or might violate state constitutional provisions and other laws relating to restraints of trade. Legal counsel should be consulted before action is taken which may affect a prepaid plan or physicians affiliated with it.
  6. Court decisions show that conflict between some of the principles of medical ethics and some aspects of a plan's operation does not automatically justify screening applicants or disciplining members because they work for the plan. Courts have held, under the circumstances of particular cases, that societies were not justified in taking action against physicians who worked for closed-panel plans in which patients did not have free choice of physician, physicians were not compensated on a fee-for-service basis, and the plan advertised and solicited members or subscribers without misrepresentation or improper conduct.
  7. These cases do not hold that these ethics or other ethics in certain circumstances do not justify action regarding membership, even though a prepaid plan may be adversely affected. Although there are no decisions under the antitrust laws involving the point, a court might well hold that false and misleading advertising and solicitation, extolling of physicians, interference by laymen in the treatment of patients, and inadequate medical care might be justification for medical society action in particular situations but the evidence would have to be clear and convincing. Whether the society's action is justified will depend on appraisal of all pertinent facts with a view to deter-

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mining whether the society's action is aimed at protecting the quality of medical care, the patient-physician relationship, the standards of the profession, and the like or instead is calculated to restrain a legitimate business. Equally dangerous as exclusion from membership are any other coercive activities designed to restrain a medical care plan. The dangers of screening applicants or disciplining members in certain circumstances because they work for a closed-panel plan, should not cause a society to conclude that membership must automatically be granted to a physician simply because he works for a plan.

8. There are certain other well-recognized areas of lawful activity available. A medical society may lawfully and properly use education, persuasion and co-operation in an effort to eliminate the evils or dangers which a society believes exist, and activities of this nature have been utilized both at the national and local levels over many years. Competition is also available if physicians object to the manner in which a particular plan in the community is operated. They may encourage the development of plans and the expansion of coverage to meet competitive situations. A medical society and members of the medical profession may also properly present views to the legislature concerning the structure, method of operation, relationship with physicians and other facets of particular plans, for the purpose of obtaining legislation to protect the public and the profession, or for the purpose of opposing legislation deemed detrimental. However, activities, otherwise lawful, may become unlawful if they are part of a conspiracy to restrain trade. Prepaid health plans sponsored by medical societies or by groups of physicians, and perhaps physicians unaffiliated with any plan, are equally entitled to the protection of laws relating to restraints of trade and interference with business, as a result of any activities of other prepaid plans. Whether in any given locality any prepaid plan in its method of operation is or will be unlawfully restraining trade can only be determined by a careful analysis of the operations of that plan. If interstate commerce is not affected, applicable state laws will have to be considered.

#### D. CONCLUSIONS CONCERNING THE OBJECTIVES OF THE COMMISSION

The following conclusions relating to the broad objectives of the Commission are based on the personal observations of the members of the committee. These opinions concerning the questions posed by the Commission are necessarily based on the information available to the committee. The members of the committee believe these opinions are sustained by their individual knowledge, judgment, and experience.

*continued on next page*

## OTITIS MEDIA or FRACTURED TIBIA?



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The following answers should be construed as more concise statements of the detailed listing of conclusions found in Parts A, B, and C of this section. They are to be read and considered in the light of, and in conjunction with, the more specific conclusions previously enumerated.

### *1. What are the effects of these plans on the quality of medical care?*

Based upon its observations, the committee believes that the quality of medical care rendered to subscribers by the units visited and, within the scope of services offered, is comparable to the average level of care which members of the committee have observed in their years of medical practice.

The quality of medical care has improved for many low income groups now covered by these plans since a considerable number live under conditions that have made the procurement of medical care a difficult problem.

The lack of continuity in medical care, which occurs in varying degrees in conventional medical practice, is an ever-present problem in the provision of medical service through such plans. Fragmented care and lack of personal follow-up characterizes a number of representative plans observed in operation. It appears in varying degrees and takes different forms, depending upon the type and scope of medical services provided by the individual plan.

### *2. What is the effect of these plans on the quantity of medical care?*

The committee believes that these plans have increased the quantity of medical care received by the segment of the population served by them. Many plans supply medical care to groups of people who would otherwise find it very difficult or inconvenient to obtain medical care, and to many people who have not been educated to seek such care.

The committee saw considerable evidence of "preventive medicine" in the way of screening programs for the early detection of syphilis, diabetes, tuberculosis, parasitic infections, cancer, and some other chronic diseases, and of educational efforts to encourage members to utilize the services available. However, the "preventive medicine" aspects of these programs, which their proponents contend are inadequately provided for by conventional medical practice, have been exaggerated by some of these plans in that such services do not prevent persons from getting sick. Also, in spite of efforts on the part of the plans to encourage beneficiaries to present themselves periodically for examination for the early diagnosis of disease, the plans are utilized, for the most part, by members for diagnosis and treatment when symptoms of illness appear.

### *3. Does the introduction of a third party in the patient-physician relationship tend to disturb it*

*and result in an inferior quality of medical care?*

The introduction of a third party in the patient-physician relationship changes it but not necessarily in such a way as to result in an inferior quality of medical care. Whether or not it does depends upon (a) what relationship existed before the introduction of a third party, and (b) a balance of the advantages and disadvantages noted later.

The addition of a new and important factor to any situation changes it. Many of the people now covered by the miscellaneous and unclassified plans visited did not have a personal physician. For these groups the introduction of a third party has resulted in more and better care for the following reasons: (1) through such prepayment plans it is easier for people in these particular lower income groups to defray the cost of good medical care; (2) people largely in the lower social and educational levels either in crowded industrial areas or in remote regions where medical care was not readily available or sought are being educated to seek medical care; (3) the plans insist upon a high grade of training for those physicians providing specialist services and their work is closely and critically scrutinized.

If such plans were extended to other groups of patients, who are cared for by competently trained physicians, who can afford to pay for their medical care, and who are educated to the value of seeking it early in the course of illness, these plans would be neither desirable nor advantageous.

The introduction of a third party may then be advantageous or disadvantageous depending upon a balance which exists in any particular plan among the following factors. The main advantages are: (1) the physician is free from concern over administrative and financial considerations involved in patient care and (2) high qualifications for the performance of specialized work are required.

The disadvantages are: (1) the flexibility in meeting the patients' needs cannot be as great because of necessary rules and regulations which are inherent in the administration of these plans; (2) the ever-present possibility that arbitrary decisions might be made by lay boards and administrators which are contrary to the provision of good quality medical care; (3) the likelihood that, due to inertia, necessary changes in procedure or equipment will not be accomplished expeditiously; (4) that by the very presence of a third party the physician bears some responsibility to it as well as to the patient; hence, the physician whose income does not depend solely upon satisfying a patient's needs may not be so responsive to them; (5) if, because of the policies followed by some plans, the patient becomes aware that his physician must look to others for direction and supervision as to the scope of care to be provided and as to procedures to be followed in providing it, the physician may

*concluded on page 190*



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## FREE CHOICE OF PHYSICIAN AND CLOSED PANEL SYSTEMS

*concluded from page 187*

lose prestige and dignity in the eyes of the patient and this may disturb the patient-physician relationship.

The patient-physician relationship need not be so disturbed if these factors are recognized, guarded against and successfully overcome.

If these plans were extended to cover a large proportion of the population so that most physicians found it mandatory to practice in them, the committee believes that many individuals with potential for making valued contributions to medicine would be deterred from entering the medical profession. It is thus likely that an ultimate adverse effect on the quality of medical care could result.

### *4. Will the plans encourage the corporate practice of medicine, especially by hospitals?*

The committee believes that constructive comments on this subject require further elaboration of the phrase "corporate practice of medicine" for the reason that it has been used, as indicated in the section dealing with Laws Relating to Miscellaneous Type Plans, to describe various types of arrangements for medical care. In addition, the question above also is expressly applicable to hospitals as

well as to arrangements concerning prepaid medical care plans. As applied to hospitals, many physicians have used the phrase "corporate practice of medicine" to refer to hospitals hiring physicians to render medical services with the hospital receiving the fees. The committee has interpreted the question, "Will the plans encourage the corporate practice of medicine, especially by hospitals?" on the assumption that the Commission would like to know whether prepaid plans studied by the committee will encourage the further development of closed panels and the use of employed physicians by plans and hospitals.

A characteristic of the prepaid direct service plans is the establishment of facilities with closed panel staffs. In some instances, plans own and operate their own hospitals. In at least one instance, the physicians are employed by the hospitals, and in others the financial arrangements are between the physicians and the plan.

If the provision of medical care by a closed panel of physicians through a third party mechanism is one form of so-called corporate practice, then the successful operation of the plans under study by the committee could well encourage the so-called corporate practice of medicine by hospitals.

### *5. What is the proper relationship between the medical profession and all third party mechanisms?*

The medical profession should assume a judicious, tolerant, and progressive attitude toward developments in the medical care field. The need for continued experimentation is recognized, and the profession should undertake, and actively participate in, the study and development of various mechanisms for the provision of medical care of high quality.

Two basic questions that must be answered, as posed by the A.M.A. House of Delegates, are:

1. Acknowledging the importance of free choice of physician, is this concept to be considered a fundamental principle, incontrovertible, unalterable, and essential to good medical care without qualification?
2. What is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician?

What are *your* answers?



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REFERENCES: 1. Carlozzi, M.: *Ant. Med. & Clin. Therapy* 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: *Ant. Med. & Clin. Therapy* 5:52 (Jan.) 1958. 3. Walch, E.: *Dent. Med. Wschr.* (April) 1956. 4. Shalowitz, M.: *Clin. Rev.* 1:25 (April) 1958. 5. Nathan, L. A.: *Arch. Pediat.* 75:251 (June) 1958. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: *Ant. Med. & Clin. Therapy* 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A.; Bamford, J., and Bradley, W.: *Ant. Med. & Clin. Therapy* 5:322 (May) 1958. 8. Harris, H.: *Clin. Rev.* 1:15 (July) 1958.

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## RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

### *Report of the Tenth Annual Meeting of the Corporation, January 26, 1959*

THE TENTH ANNUAL MEETING of the Corporation of the Rhode Island Medical Society Physicians Service was held at the Blue Cross Building, 31 Canal Street, Providence, Rhode Island, on Monday, January 26, 1959.

The meeting was called to order by the president, Charles J. Ashworth, M.D., at 8:15 P.M. Doctor Ashworth introduced the present and past non-physician members of the Board of Directors who were present at the meeting.

The following members of the Corporation were in attendance:

Samuel Adelson, M.D.	Edmund T. Hackman, M.D.
Charles J. Ashworth, M.D.	John J. Hall
Robert R. Baldrige, M.D.	John J. Halloran
Irving A. Beck, M.D.	John C. Ham, M.D.
Joseph A. Bliss, M.D.	Robert C. Hayes, M.D.
J. Robert Bowen, M.D.	Albert H. Jackvony, M.D.
Alex M. Burgess, Jr., M.D.	Alexander A. Jaworski, M.D.
Bertram H. Buxton, Jr., M.D.	Walter S. Jones, M.D.
Wilfred I. Carney, M.D.	Ernest K. Landsteiner, M.D.
Francis H. Chafee, M.D.	Frank J. Logler, M.D.
George W. Chaplin	Frank C. MacCardell, M.D.
Philomen P. Ciarla, M.D.	Earl J. Mara, M.D.
G. Edward Crane, M.D.	James McGrath, M.D.
Harry E. Darrach, M.D.	Edward A. McLaughlin, M.D.
Michael DiMaio, M.D.	Joseph G. McWilliams, M.D.
John E. Donley, M.D.	William S. Nerone, M.D.
James R. Donnelly	Donald K. O'Hanian, M.D.
Robert W. Drew, M.D.	Thomas Perry, Jr., M.D.
Frederick C. Eckel, M.D.	Arnold Porter, M.D.
Peter Erinakes, M.D.	Alfred L. Potter, M.D.
Charles L. Farrell, M.D.	William A. Reid, M.D.
William J. H. Fischer, Jr., M.D.	Ralph D. Richardson, M.D.
Henry F. Fletcher, M.D.	Francis B. Sargent, M.D.
Ferdinand S. Forgiel, M.D.	Carl S. Sawyer, M.D.
Henri E. Gauthier, M.D.	William J. Schwab, M.D.
J. Merrill Gibson, M.D.	John Shepard II
John F. W. Gilman, M.D.	James J. Sheridan, M.D.
Seebert J. Goldowsky, M.D.	Robert D. Stuart
Hartford P. Gongaware, M.D.	M.D. Saul A. Wittes, M.D.
Stanley Grzebień, M.D.	Hrad H. Zolmian, M.D.

Also present were Stanley H. Saunders, executive director, Edgar H. Clapp, associate executive director, William E. McCabe, legal counsel, and John E. Farrell, Sc.D., executive secretary.

#### *Address of the President*

Doctor Ashworth gave his annual report on the experience of Physicians Service during the year 1958. Copy of this report is made part of the official

minutes of the meeting.

#### *Annual Report of the Secretary*

Doctor Ernest K. Landsteiner, secretary of the Corporation, read his annual report, copy of which had been distributed to each member of the Corporation.

It was moved that the report be received and placed on file. The motion was seconded and adopted.

#### *Annual Report of the Treasurer*

Mr. James Donnelly, treasurer, read his report for the year 1958, copy of which is made part of the official minutes of the meeting. It was moved that the report be received and placed on file. The motion was seconded and adopted.

#### *Report on Extended Plan*

The secretary read a report from the Board of Directors on the extended benefits plan as adopted by the Board at its meeting on January 19, 1959.

Copy of the report was distributed to each member of the Corporation and copy is made part of the official minutes of this meeting.

It was moved that the report be accepted and the recommendations in it be adopted. The motion was seconded and adopted.

There was general discussion by members of the Corporation of the various recommendations in the report.

The motion was passed.

#### *Election of Physician Members to the Board*

The president noted that the House of Delegates nominates four physicians annually to serve on the Board of Directors. He also noted that the House of Delegates would meet after the meeting of the Corporation.

It was moved that the secretary be empowered to cast a vote for the Corporation to elect the physicians nominated by the House of Delegates of the Rhode Island Medical Society to serve as directors on the Board of Directors of the Rhode Island Medical Society Physicians Service. The motion was seconded and passed.

#### *Report of the Executive Director*

Mr. Stanley H. Saunders, executive director of

*continued on page 194*

# *Rhode Island Medical Society*

## *Physicians Service*

### OFFICERS—1959

CHARLES J. ASHWORTH, M. D. . . . . *President*  
 EARL J. MARA, M. D. . . . . *Vice President*  
 CHARLES L. FARRELL, M. D. . . . . *Secretary*  
 JAMES R. DONNELLY . . . . . *Treasurer*

### BOARD OF DIRECTORS

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J. AUSTIN CARROLL	JOHN J. HALL
GEORGE W. CHAPLIN	FRANK J. LOGLER, M. D.
JAMES R. DONNELLY	EARL J. MARA, M. D.
FREDERICK C. ECKEL, M. D.	WILLIAM A. REID, M. D.
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WILLIAM J. H. FISCHER, M. D.	ORLAND F. SMITH, M. D.
HENRI E. GAUTHIER, M. D.	ROBERT D. STUART

EXECUTIVE OFFICE: 106 Francis Street, Providence 3, R. I.

*Executive Secretary:* JOHN E. FARRELL, Sc. D.

ADMINISTRATIVE OFFICE: 31 Canal Street, Providence 2, R. I.

*Executive Director:* STANLEY H. SAUNDERS

### STANDING COMMITTEES

#### *Executive Committee*

CHARLES J. ASHWORTH, M. D., *Chairman*  
 JAMES R. DONNELLY  
 CHARLES L. FARRELL, M. D.  
 WILLIAM J. H. FISCHER, JR., M. D.  
 FRANCIS B. SARGENT, M. D.

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WILLIAM J. H. FISCHER, M. D., *Chairman*  
 SEEBERT J. GOLDOWSKY, M. D.  
 EDMUND T. HACKMAN, M. D.

#### *Finance Committee*

MR. JAMES R. DONNELLY, *Chairman*  
 CHIELCIE C. BOSLAND, PH. D.  
 MR. GEORGE W. CHAPLIN

#### *Conference Committee*

HENRI E. GAUTHIER, M. D., *Chairman*  
 JOHN J. HALL  
 WILLIAM A. REID, M. D.

# RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

*continued from page 192*

Physicians Service, gave an oral report citing the steady progress of the program over the ten-year period which has resulted in the enrollment of 63% of the eligible Rhode Island population. He praised the Board of Directors for its development of sound policies through the years, and he discussed various problems that had been faced during 1958 in the operation of the Plan.

## *Adjournment*

The meeting of the Corporation was adjourned at 9:10 P.M.

Respectfully submitted,

ERNEST K. LANDSTEINER, M.D., *Secretary*

## *Annual Report of the Secretary*

At the Annual Meeting of the Board of Directors of the Rhode Island Medical Society Physicians Service Corporation, held on February 10, 1958, the following were elected as officers:

Charles J. Ashworth, M.D.	<i>President</i>
Earl J. Mara, M.D.	<i>Vice-President</i>
Ernest K. Landsteiner, M.D.	<i>Secretary</i>
Mr. James R. Donnelly	<i>Treasurer</i>

The Board elected as its representatives of the public the following: Mr. George W. Chaplin, vice-president, Industrial National Bank; Mr. John J. Hall, director of Industrial Relations, Brown and

# RHODE ISLAND MEDICAL JOURNAL

Sharpe Manufacturing Company; Mr. Robert D. Stuart, president, Blackstone Valley Gas and Electric Company; Mr. James R. Donnelly, manager of the Pawtucket Office of the Rhode Island Hospital Trust Company; Mr. Felix A. Mirando, president of the Imperial Knife Company; and Professor Chelcie C. Bosland, of Brown University. The last two named directors were nominated by the Hospital Service Corporation of Rhode Island in accordance with the state statute.

In recognition of their long and valued service as members of the Board of Directors, the following non-physicians were elected to the Corporation during the year: Mr. John Shepard II, Mr. John J. Halloran, Mr. Walter F. Farrell, Mr. George R. Ramsbottom, and Mr. Emil E. Fachon.

During the year the Board held six meetings, and its Executive Committee three meetings. All authorized standing committees were appointed, and all were active in their assigned tasks in connection with the progress, development and management of the affairs of the Corporation.

Of major interest has been the study involved in the extension of the program to provide increased benefits, and ultimately major medical coverage. The Board has also considered provisions in supplemental contracts relative to diagnostic laboratory services, and such other problems as expansion of the direct enrollment campaign; review of legislative proposals; participating physician agreements; extension of benefits for mental, tuberculosis and other chronic illnesses; dental provisions; accident room coverage, and public information programs.

The progressive development of Physicians Service is compared in the attached summary of statistics for the years 1957 and 1958 which is made part of the report.

Respectfully submitted,

ERNEST K. LANDSTEINER, M.D., *Secretary*

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— Dryden

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*Rhode Island Medical Society Physicians Service  
Comparison of Statistics — Years 1957 and 1958*

	1957	1958	Increase or (Decrease)
Subscribers .....	505,313	521,434	16,121
Number of Firms Buying Physicians Service .....	1,090	1,155	65
Number of Participating Physicians .....	915	912	(3)
Total of Claims Paid .....	\$5,796,851	\$6,254,485	\$457,634
Total of Claims Paid Since Start of Plan .....	\$26,547,374	\$32,801,859	\$6,254,485
Total Assets .....	\$3,266,901	\$3,676,127	\$409,226
Total Income .....	\$6,632,356	\$6,795,099	\$162,743
Total Reserves .....	\$1,592,957	\$1,780,064	\$187,107
Operating Expenses .....	\$335,949	\$391,415	\$55,466
Operating Expense—% .....	5.1%	5.8%	0.7%
Ratio of Claims to Income .....	87.4%	92.0%	4.6%

*Number of Cases Paid:*

*Surgeons .....	79,554	84,235	4,681
*Assistants .....	12,934	13,026	92
*Anesthetists .....	20,873	28,623	1,750
Medical .....	13,756	15,923	2,167
X ray and E. K. G. ....	81,529	89,220	7,691
TOTAL .....	214,646	231,027	16,381

*Maternity Cases (included in above) .....	10,958	10,151	(807)
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\* \* \*

*Report of the Treasurer**Balance Sheet as of December 31, 1958**Assets*

Cash on Hand .....	\$ 215,484.46	—	145,950.54
Accounts Receivable (Hospital Service Corp.) .....	615,346.28	+	42,441.83
Investments: Government Securities .....	2,845,296.27	+	512,734.63
TOTAL ASSETS .....	\$3,676,127.01	+	409,225.92

*Liabilities and Reserves*

Accounts Payable: Surgical and Medical Services and Hospital Service Corp. ....	\$ 614,097.66	+	133,494.50
Accrued Surgical-Medical Expense .....	467,737.00	+	82,490.00
Accrued for Maternity Benefits .....	514,543.00	—	37,908.00
Unearned Subscriptions .....	299,685.00	+	44,042.55
TOTAL LIABILITIES .....	\$1,896,062.66	+	222,119.05
Reserves .....	1,780,064.35	+	187,106.87
TOTAL LIABILITIES AND RESERVES .....	\$3,676,127.01	+	409,225.92

*Statement of Income and Expense*

INCOME			
from Subscriptions .....	\$6,724,719.37	+	92,362.67
EXPENSES			
Surgical and Medical Claims .....	\$5,289,978.14	+	341,491.90
X ray and E. K. G. ....	964,507.04	+	116,142.14
Operating Expense .....	391,414.99	+	55,465.23
TOTAL OPERATING EXPENSES .....	\$6,645,900.17	+	513,099.27
Net Operating Gain .....	\$ 78,819.20	—	420,736.60
Income from Investments .....	70,379.67	+	16,635.70
TOTAL NET INCOME .....	\$ 149,198.87	—	350,356.93

Number of Subscribers increased 16,121 for a total of 521,434.

Total cases 231,027, an increase of 16,381 cases.

Respectfully submitted,  
JAMES R. DONNELLY, Treasurer

# THE HOUSE-CALL ANTIBIOTIC

*Wide range of action is reassuring when culture and sensitivity tests are impractical.*

*Effectiveness demonstrated in more than 6,000,000 patients since original product introduction (1956).*

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glucosamine-potentiated tetracycline  
with triacetyloleandomycin

capsules ■ oral suspension ■ pediatric drops


125 mg.  
250 mg.

raspberry flavored,  
2 oz. bottle, 125 mg.  
per teaspoonful (5 cc.)

raspberry flavored,  
10 cc. bottle (with  
calibrated dropper),  
5 mg. per drop (100 mg.  
per cc.)

**REFERENCES:** 1. Adams, J.: Advantages of combined tetracycline-oleandomycin therapy in common infections, *J. Tennessee M. Assoc.* 50:446 (Nov.) 1957. 2. Andersson, B.: Pulmonary abscess cured with antibiotics, *Opuscula Medica*, 2:8 (Oct.) 1957. 3. Ancello, V. J., and Gerschenfeld, D. S.: Staphylococcal septicemia in a child: Treatment with a combination of oleandomycin and tetracycline, *Dia med.*, B. Air. 30:1921 (July 28) 1958. 4. Arneil, G. C.: Tetracycline-oleandomycin treatment of acute respiratory disease in childhood, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., October 1958, to be published. 5. Arrigoni, G.; Grignani, G. C., and Varesi, M.: A new antibiotic association in the treatment of urologic infections, *Minerva med.* 48:2701 (Aug. 25) 1957. 6. Baccaredda Boy, A., and Cappelli, E.: Clinical study of the activity of a new antibiotic preparation, Signemycin, in skin conditions of infectious (pyogenous) origin, *Minerva med.* 48:2690 (Aug. 25) 1957. 7. Bergdahl, L.: Clinical experiences with a so-called double-spectrum antibiotic, Signemycin, *Svenska Lakartidningen* 55:1715, 1958. 8. Blundi, E.: Use of Signemycin in a chest clinic, to be published. 9. Bolognesi, C.: Preliminary results of the use of Signemycin in certain otorhinolaryngological infections due to pyogenic organisms, *Minerva med.* 48:2693 (Aug. 25) 1957. 10. Brodhage, H.: Bakteriologische in-vitro-versuche mit einer Kombination von tetracyclin und oleandomycin (Signemycin), *Praxis* 26:579, 1957. 11. Calvi, A.: Antibiotics in the therapy of influenza and its pulmonary complications, to be published. 12. Carter, C. H., and Maley, M. C.: Application of tetracycline-oleandomycin in clinical practice, *Antibiotics Annual* 1956-57, New York, Medical Encyclopedia, Inc., 1957, p. 51. 13. Castellanos, A.: Signemycin in pediatrics, to be published. 14. Chiappara, P.: A case of sepsis with multiple osteomyelitis treated with a new antibiotic, *Minerva med.* 48:2697 (Aug. 25) 1957. 15. Chiarenza, A.: Observations on the effects of Signemycin in nongonococcal urethritis, *Minerva med.* 48:2692 (Aug. 25) 1957. 16. Cimmino, A.; Boni, A., and Orsi, N.: Antibiotic activity of oleandomycin-tetracycline combination. *In vitro* study on 332 strains of *Micrococcus pyogenes* var. *aureus* clinically isolated, *Antibiotics Annual* 1957-1958, New York, Medical Encyclopedia, Inc., 1958, pp. 708-715. 17. Cooper, J.; Sprogis, G. R.; Heinemann, M., and Ferrer, G. M.: Therapy of amebiasis carriers with oleandomycin-tetracycline (Signemycin), *Antibiotic M.* 5:302 (May) 1958. 18. Cornbleet, L., and Firestein, B. Z.: Use of oleandomycin-tetracycline (Signemycin) for acne, *Antibiotic M.* 4:598 (Oct.) 1957. 19. Cupples, J. F. B., and Perry, A. W.: Acute staphylococcal endocarditis treated with tetracycline-oleandomycin successfully, *Canad. M. Assoc. J.* 77:699 (Oct.) 1957. 20. Davis, W. G.: Report on tetracycline and oleandomycin used in combination, *Clinical Review & Research Notes*, 1:21-23 (April) 1958. 21. DeRomana, J.; Zaldivar, C., and Falcone, F.: Actual therapeutic conduct in the treatment of osteomyelitis, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 1958, to be published. 22. Durricio, C. A.; Rodriguez, J. B., and Petrella, E.: The use of oleandomycin-tetracycline in buccal surgery, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 1958, to be published. 23. English, A. R.; McBride, T. J.; Van Halsem, G., and Carlozzi, M.: Biologic studies on PA-775, a combination of tetracycline and oleandomycin with synergistic activity, *Antib. & Chemo.* 6:511-522 (Aug.) 1956. 24. Farah, L.: Some therapeutic indications of Signemycin, *Medicina, Mex.* 783:519 (Nov.) 1957. 25. Faz Tabio, H.: Severe enterosepsis treated with Signemycin, *Rev. cubana pediat.* 29:3 (May) 1957. 26. Faz Tabio, H.: Signemycin in the treatment of certain diseases of the respiratory tract, *Rev. cubana pediat.* 30:219 (Apr.) 1958. 27. Febles, D., and Biderman, I.: Antibiotic management of acute infections in the obstetric patient, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 1958, to be published. 28. Felder, J.: Signemycin in der pediatrie, *Schweiz. med. Wschr.* 88:953 (Sept. 27) 1958. 29. Fiora, F., and Compa, F.: The combination antibiotic oleandomycin-tetracycline (Signemycin) in acute blennorrhagia, *Dia med.* B. Air. 30:570 (Apr. 3) 1958. 30. Florio, I., and Scopetta, F. P.: Signamycin ed occlusione intestinale sperimentale, *Bulletin med. & surg. soc.*, Pavia, 71:1, 1957. 31. Foradori, M.: A case of meningitis due to *Staphylococcus aureus* complicating tubercular meningitis, treated successfully with Signemycin, *Minerva med.* 48:2707 (Aug. 25) 1957. 32. Frank, L., and Stritzler, C.: Newer antibiotics in the treatment of acne, *Antibiotic M.* 4:419 (July) 1957. 33. Friedrich, K., and Hammer, H.: A new treatment for bacterial infection with an antibiotic combination, to be published. 34. Gemma, G. B.; Mel, C., and Bachi, V.: First experiences with Signemycin in surgical infections, *Minerva med.* 48:2643 (Aug. 25) 1957. 35. Gilley, E. W.: Clinical appraisal of tetracycline and oleandomycin used in combination, to be published. 36. Haagen, H., and Scheffler, H.: Preliminary clinical experience with oleandomycin and the double-spectrum antibiotic, Signemycin, *Medizinische, J.* 4:477 (Apr. 6) 1957. 37. Harris, H. J.: Tetracycline and oleandomycin (Signemycin) in chronic brucellosis, to be published. 38. Hasenclever, H. F.: Comparative *in vitro* studies of hospital strains of *Staphylococcus aureus* with oleandomycin, tetracycline and an oleandomycin-tetracycline mixture, *Antibiotic M.* 5:14-25 (Jan.) 1958. 39. Hegelin, R.: Ornithosis, *Schweiz. med. Wschr.* 3:64, 1958. 40. Henne, H. F.: Clinical experiences with the double-spectrum antibiotic Signemycin, *Med. Klin., Berl.* 2:1267-1270 (July 18) 1958. 41. Heredia Diaz, J.; Saavedra Zavaleta, G.; Robles, M. A., and Aguilar, D. L.: Tetracycline-oleandomycin (Signemycin) in the treatment of puerperal infections, *Medicina, Mex.* 38:308, 1958. 42. Hoffmann, H.: Clinical experiences with the broad-spectrum antibiotic, Signemycin, *Medizinische, J.* 4:1850 (Nov. 8) 1958. 43. Hoz Fabra, J.: Preliminary results of a clinical trial with Signemycin, *Rev. clin. espan.* 67:101 (Oct. 31) 1957. 44. Kaiser, J. A.; Mazzarino, C.; Bajek, E. M., and P'an, S. Y.: Oleandomycin-tetracycline: Toxicity in experimental animals, *Antibiotics & Chemother.* 7:255-259 (May) 1957. 45. Kance, B., and Cockcroft, W. H.: Clinical and bacteriological studies on Signemycin (Oleandomycin-tetracycline) ointment, *Canad. M. Assoc. J.* 78:614 (Apr. 15) 1958. 46. Keil, P. G.; Tieszen, R. L., and Solomon, R. J.: An evaluation of Signemycin in the treatment of pneumonia, to be published. 47. Klovstad, O.: Signemycin "Pfizer" a combination of oleandomycin and tetracycline, *Tidsskr. norske lægefor* 15:681 (Aug.) 1957. 48. Kohler, H. F.: Case report of the month: chronic osteomyelitis, *Clinical Review & Research Notes*, 1:16 (Apr.) 1958. 49. Kraljevic, R., et al.: Investigation of the therapeutic value of the combination of tetracycline and oleandomycin, *Antibiotic M.* 5:364-371 (June) 1958. 50. Kraljevic, R.: Discussion of the paper by Florentin and Sison (The role of antibiotics in Asian Influenza), *Antibiotics Annual* 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 948. 51. Kraljevic, R.; Pearson, E., and Borgano, J. M.: Combined oleandomycin-tetracycline therapy in respiratory tract and other infections, to be published. 52. LaCaille, R. A., and Prigot, A.: Combinations of oleandomycin with oxytetracycline and tetracycline in soft-tissue infections, *Antibiotics Annual* 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 67. 53. Levi, W. M., and Kredel, F. E.: A clinical trial of Signemycin, *South Carolina M. J.* 53:178 (May) 1957. 54. Lewis, H. M.; Frumess, G. M., and Henschel, F. J.: Treatment of skin infections with tetracycline and oleandomycin, *Rocky Mountain M. J.* 54:806 (Aug.) 1957. 55. Lopez, A. V., and Cohen, H. J.: The clinical trial of a combination of tetracycline hydrochloride and oleandomycin (oral suspension) in the treatment of severe pulmonary infections in children, to be published. 56. Loughlin, E. H., and Mullin, W. G.: Combined antibiotic therapy of tropical infections with Matroterra and Signemycin, *Antibiotics Annual* 1957-58, New York, Medical Encyclopedia, Inc., 1958, p. 698. 57. Loughlin, E. H., and Mullin, W. G.: Combined antibiotic therapy of tropical infections with PA-765 and PA-775, *Antibiotics Annual*

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1956-57, New York, Medical Encyclopedia, Inc., 1957, p. 63. 58. McCloud, L. C.; Shidal, W., and Mulligan, J. L.: Clinical observations on infections treated with a combination of tetracycline and oleandomycin, to be published. 59. McFadden, H. W., and Schelhart, D.: Comparison of the *in vivo* sensitivity of micrococci to oleandomycin, tetracycline and a combination of oleandomycin and tetracycline, *Antibiotics Annual* 1957-1958, New York, Medical Encyclopedia, Inc., 1958, pp. 514-519. 60. Manara, G., and Gasparetto, A.: The first clinical experience with water-soluble Signemycin, *University of Padua, Minerva chirurgica* 13:535 (May 15) 1958. 61. Medina Morales, F.: The combination of tetracycline-oleandomycin (Signemycin) in the postoperative treatment of three cases of pulmonary resection, *Medicina, Mex.* 800:347, 1958. 62. Mehra, B. K.: Combating the resistant staphylococci, *Current Med. Pract.* 1:326-328 (May) 1957. 63. Mendiola, R.; Naranjo, R., and Brisenio, F.: New contributions to the treatment of tuberculosis, *Medicina, Mex.* 37:269 (June 25) 1957. 64. Mendoza Diez, J.: Treatment of osteomyelitis with Signemycin, Thesis, Universidad Nacional Mayor de San Marcos, Facultad de Medicina, Lima, Peru, 1957. 65. Moggian, G.: Preliminary results of a new antibiotic association in obstetrics and gynecology, *Minerva med.* 48:2648 (Aug. 25) 1958. 66. Molinelli, E. A.; Vera Barros, E., and Ithurralde, D.: Tetracycline-oleandomycin in human brucellosis therapy, *Antibiotics Annual* 1957-58, New York, Medical Encyclopedia, Inc., 1958, pp. 692-697. 67. Montilli, G., and Avellino, M.: Esperienze con una nuova associazione di antibiotici (tetraciclina ed oleandomicina) in terapia dermatologica, *Dermatologia* 9:3, 1958. 68. Morador, J. L., and Morador, S.: Cause, prevention and treatment of staphylococcal infection in hospitals, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 1958, to be published. 69. Morador, J. L., and Tate, L. S.: Treatment of 52 cases of infections caused by coagulase-positive staphylococci with a combination of oleandomycin and tetracycline, *Antibiotics Annual* 1957-58, New York, Medical Encyclopedia, Inc., 1958, pp. 702-707. 70. Morador, J. L., and Tate, L. S.: The treatment of anorectal infections with Signemycin, *An. Ateneo Clin. Quirur.* 1:52 (Jan.) 1958. 71. Morel, A. S.: Surgical infections: a guide to therapy, *Clinical Review & Research Notes* 1:18-21 (July) 1958. 72. Morey, G. S.: Infections in nursing babies due to *Pseudomonas aeruginosa* (*B. pyocyaneus*) alone or associated with other organisms, *Rev. Hosp. nino*, 72:3, 1958. 73. Oates, J. K.: Trial of Signemycin in non-specific urethritis, *Brit. J. Vener. Dis.* 34:38, 1958. 74. O'Hertly, F. C.: A clinical trial with Signemycin, *Medical Press* (London), p. 897 (Sept. 17) 1958. 75. Olmer, J., and Casanova, P.: Therapeutic notes: Clinical trials of Signemycin in the treatment of 59 patients, *Semaine hop. Paris*, Vol. 34, no. 2 (Feb.) 1958. 76. Otolenghi, C. E.; Frigerio, E. R., and Soto Jimenez, D.: Combined antibiotic therapy in 35 cases of osteomyelitis, *Bol. y trab. Soc. cir. Buenos Aires*, 41:739, 1957. 77. Pagola, J. G.; Benavides, L., and Heredia, A.: An evaluation of tetracycline-oleandomycin in the treatment of epidemic typhus, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 1958, to be published. 78. Pavone, M.; Anello, A., and Macaluso, M. P.: Signemycin in the therapy of infections of urinary passages, to be published. 79. Perez Villante, G.: Postoperative treatment of the ear cavity, *An. Soc. Mexico de Otorinolaringologia*, No. 34-35:175 (May-Aug.) 1957. 80. Prokop, O.: On the question of staphylococcus infections resistant to therapy, *Der Praktische Arzt*, 12:145 (Feb. 15) 1958. 81. Quarti, M.: Efficacy of the association of oleandomycin and tetracycline in staphylococcal infections, *Aggiornamento Pediatrico*, 8:11, 1957. 82. Quirno, N.; Fekelman, R., and Achaval, M.: Treatment with oleandomycin-tetracycline of infections observed in clinical practice, *Dia med.* 30:2938 (Nov. 17) 1958. 83. Ragazzini, F.; Moggi, P., and Accella, M.: First clinical applications of Signemycin in pediatrics, *Minerva med.* 48:2667 (Aug. 25) 1957. 84. Randig, K.: Some experiences with Signemycin, *Deutsches med. J.* 8:447 (Aug. 15) 1957. 85. Rebelledo, L. M., and Heredia, D. J.: Further clinical studies of an association of tetracycline and oleandomycin in the treatment of various infections, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 1958, to be published. 86. Rentchnick, P.: A combination of broad-spectrum antibiotics, *Medicine et Hygiene*, 379:562 (Nov. 30) 1957. 87. Revelli, E., and Durando, C.: Treatment of the nonspecific inflammatory component of tuberculosis of the female genital organs, *Minerva med.* 48:2658 (Aug. 25) 1957. 88. Rivera, J. A.; Braine, R. E., and Osborne, D.: Sensitivity of *Micrococcus pyogenes* from burned patients to the action of oleandomycin. The emergence of resistance to this antibiotic, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 1958, to be published. 89. Rondanelli, E. G.: The therapeutic problem of orchitis by parotitic virus, *Institute of General Clinical Medicine and Medical Therapy of the University of Pavia, Bulletin med. & surg. soc.*, Pavia, 71:1, 1957. 90. Saavedra Amaro, S., and Lopez Zepeda, L.: Comprobacion clinica de la Signemycin en el tratamiento de infecciones diversas, to be published in *Medicina, Mex.* 91. Sanchez Creus, P.: Los antibioticos de indicaciones limitadas, *Rev. clin. espan.* 69:378 (June 30) 1958. 92. Sanguinolo, F.: Therapeutic action of the tetracycline-oleandomycin (Signemycin) association, *Minerva med.* 48:2679 (Aug. 25) 1957. 93. Santos, A. A.; Ganora, H. M., and Brea, C. M.: Antibiotic prophylaxis in thoracic surgery, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 1958, to be published. 94. Schenone, H.: Genitourinary infections treated with the antibiotic combination tetracycline and oleandomycin, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 1958, to be published. 95. Shubin, H.: Clinical evaluation of combined chemotherapy, oleandomycin and tetracycline, *Antibiotic M.* 4:174 (March) 1957. 96. Signer, A., and Vinci, G. G.: Signemycin in the healing of wounds, *Arch. Societa Med-Chirur.* Messina, Vol. II, 1957. 97. Smazal, S. F., and Crowley, P. J.: Routine use of the antibiotics tetracycline and oleandomycin in combination for the treatment of infections represented in an unselected series of general office patients, to be published. 98. Steinman, E.: Trial of an antibiotic combination as a routine agent for treatment of infections in office practice, to be published. 99. Stritzler, C., and Frank, L.: Significance of the response of acne vulgaris to antibiotics, *Antibiotic M.* 5:109 (Feb.) 1958. 100. Talbot, J. R.: Experience with an antibiotic combination (tetracycline-oleandomycin) used routinely for anti-infective therapy in an office practice, *Wisconsin M. J.* 57:237-238 (June) 1958. 101. Tato, J. M.; Galli, L. A.; Rehniewski, C.; Arauz, S.; Games, J.; Bello, J.; de Sebastian, G., and Berzaglio, O.: Treatment of chronic sinusitis with a combination of oleandomycin and tetracycline, *Antibiotics Annual* 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 675. 102. Wilcox, R. R.: Tetracycline and oleandomycin in combination in nongonococcal urethritis, *Antibiotics Annual* 1957-58, New York, Medical Encyclopedia, Inc., 1958, p. 672. 103. Wilcox, R. R.: The treatment of nongonococcal urethritis with tetracycline and oleandomycin in combination (Signemycin), *Medical Press* (London) (Dec. 11) 1957. 104. Willemot, J. P., et al.: Signemycin in the treatment of pulmonary infections, *Bruxelles med.* 38:1026 (June 22) 1958. 105. Winton, S. S., and Chesrow, E. J.: A clinical study of combined chemotherapy, *Antibiotics Annual* 1956-57, New York, Medical Encyclopedia, Inc., 1957, p. 55. 106. Wittmoser, R.: Hospitalismus, *Chirurgische Praxis*, 3:281 (Sept.) 1957. 107. Zaldivar, C. G., and Falcone, F.: Preliminary results in osteomyelitis with tetracycline and the phosphate of oleandomycin (Signemycin), *Rev. Hosp. nino* 18:151 (June) 1957. 108. Zaldivar, C. G.: Complicated forms of chronic osteomyelitis, *Rev. Hosp. nino* 72:315 (Dec.) 1957.



## HOUSE OF DELEGATES *of the* RHODE ISLAND MEDICAL SOCIETY

*Report of Meeting held January 26, 1959*

A REGULAR MEETING of the House of Delegates of the Rhode Island Medical Society was held on Monday, January 26, 1959, at the Blue Cross Building, 31 Canal Street, Providence, Rhode Island. The meeting was held subsequent to a meeting of the Corporation of the Rhode Island Medical Society Physicians Service, and it was called to order by the president of the Society, Doctor Francis B. Sargent, at 9:25 p.m.

The following delegates answered the roll call of the secretary:

*Bristol County:* Robert W. Drew, M.D. *Kent County:* Peter C. Erinakes, M.D.; Edmund T. Hackman, M.D.; Donald K. O'Hanian, M.D. *Norfolk County:* Philomen P. Ciarla, M.D. *Pawtucket District:* Ferdinand S. Forgiel, M.D.; Robert C. Hayes, M.D.; Alexander Jaworski, M.D.; Hrad H. Zolmian, M.D. *Washington County:* Hartford P. Gongaware, M.D.; James A. McGrath, M.D. *Woonsocket District:* Joseph A. Bliss, M.D.; Saul A. Wittes, M.D. *Officers of the RIMS:* (other than delegates): Francis B. Sargent, M.D.; Samuel Adelson, M.D.; Alfred L. Potter, M.D.; Thomas Perry, Jr., M.D. *Providence Medical Association:* Robert R. Baldrige, M.D.; Irving A. Beck, M.D.; J. Robert Bowen, M.D.; Alex M. Burgess, Jr., M.D.; Bertram H. Buxton, Jr., M.D.; Wilfred I. Carney, M.D.; Francis H. Chafee, M.D.; Harry E. Darrah, M.D.; Michael DiMaio, M.D.; William J. H. Fischer, M.D.; Henry B. Fletcher, M.D.; J. Merrill Gibson, M.D.; John F. W. Gilman, M.D.; Seebert J. Goldowsky, M.D.; Stanley Grzebien, M.D.; John C. Ham, M.D.; Walter S. Jones, M.D.; Ernest K. Landsteiner, M.D.; Frank C. MacCardell, M.D.; Joseph G. McWilliams, M.D.; William S. Nerone, M.D.; Arnold Porter, M.D.; William A. Reid, M.D.; Ralph D. Richardson, M.D.; Carl S. Sawyer, M.D.; William J. Schwab, M.D.; James J. Sheridan, M.D. *Editor of R. I. Medical Journal:* John E. Donley, M.D. *Delegate to A.M.A.:* Charles J. Ashworth, M.D.

Also present were Doctor Stanley Sprague, chairman of the Society's Industrial Health Committee, and John E. Farrell, Sc.D., executive secretary.

### REPORT OF THE PRESIDENT

Doctor Sargent reported that he had named Doctor Reuben C. Bates as the Society's representative on the Board of Directors of the Quality Milk Control Association, and Doctor Henry E. Utter as alternative representative.

He reported on the development of plans by the Group Professional Liability Insurance Committee for a new carrier for the Society's group plan.

### REPORT OF THE SECRETARY

Doctor Thomas Perry, Jr., secretary, noted that his report had been submitted to the delegates in their handbook. There was brief discussion of several of the items in the report.

*Action:* It was moved that the report of the secretary be received and placed on file. The motion was seconded and adopted.

### *Report of the Treasurer*

The president noted that the report of the treasurer had been presented in the handbook of the delegates.

*Action:* It was moved that the report of the treasurer be accepted and placed on file. The motion was seconded and adopted.

### *Nominees for Physicians Service Directors*

The president called for nominees to serve for three-year terms on the Board of Directors of Physicians Service. The following physicians were placed in nomination: Doctors Charles J. Ashworth, G. Edward Crane, Seebert J. Goldowsky, Albert H. Jackvony, Francis W. Nevitt, Thomas Perry, Jr., William A. Reid, and Francis B. Sargent.

Also placed in nomination were Doctors Ernest K. Landsteiner and Harry E. Darrah, but these physicians requested that their names be withdrawn.

The motion was made and adopted that the list of nominees be closed.

On a written ballot the following received the highest votes and were declared the nominees of the House of Delegates and the elected members of the Board of Directors of Physicians Service to serve until the Annual Meeting of that Corporation

in 1962: Doctors Ashworth, Goldowsky, Reid, and Sargent.

### *Benevolence Fund*

The president noted that the report of the trustees of the Benevolence Fund was included in the handbook.

*Action:* It was moved that the report be received and placed on file. The motion was seconded and adopted.

### *Cancer Committee*

The president noted that the report of the Cancer Committee was included in the handbook.

*Action:* It was moved that the report be received and placed on file. The motion was seconded and adopted.

### *Industrial Health Committee*

Doctor Stanley Sprague, chairman of the Industrial Health Committee, reviewed the report of his Committee, copy of which was submitted to each delegate in his handbook. He reported that Governor DeSesto has named a committee to study the problems of Workmen's Compensation insurance and he expressed the hope that the Medical Society might participate in this study.

*Action:* It was moved that the report of the Industrial Health Committee be received and placed on file. The motion was seconded and adopted.

### *Maternal Health*

The president noted that the report of the Maternal Health Committee was included in the handbook. He also directed attention to the suggestion of the Committee that a Perinatal Mortality Committee be appointed.

*Action:* It was moved that the report of the Maternal Health Committee be received and placed on file and that the president be authorized to appoint a Perinatal Mortality Committee. The motion was seconded and adopted.

### *Mental Health*

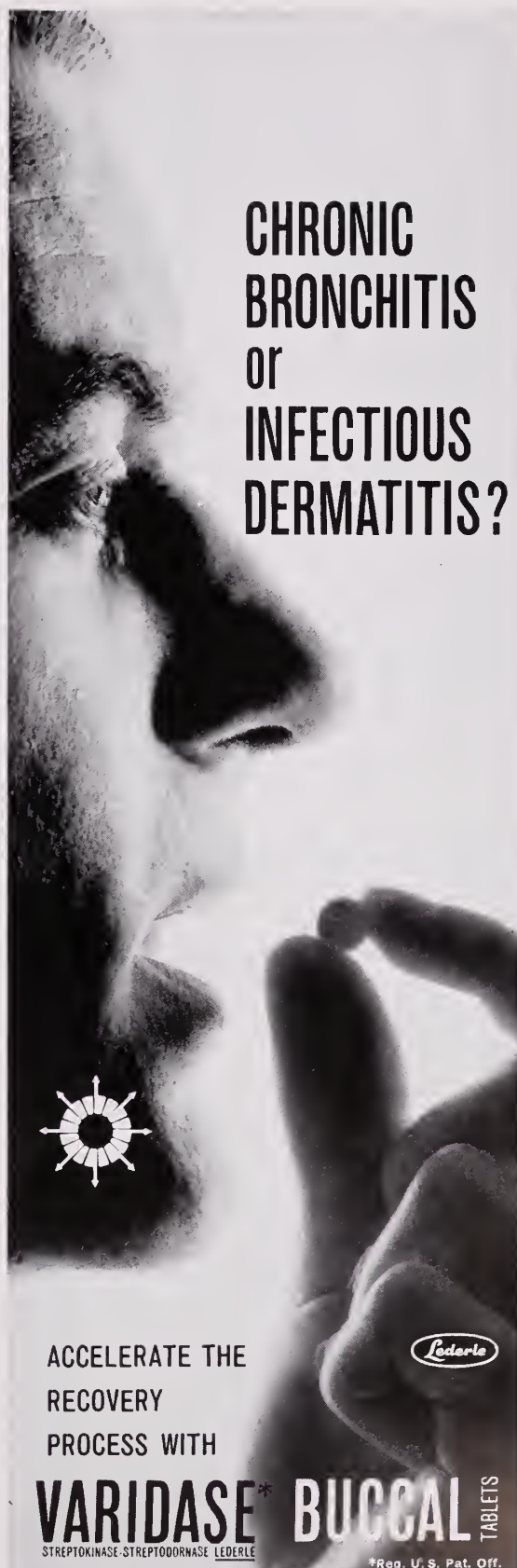
The president noted that the report of the Mental Health Committee was included in the handbook.

*Action:* It was moved that the report of the Mental Health Committee be received and placed on file. The motion was seconded and adopted.


### *Physicians on Hospital Boards of Trustees*

The president stated that the handbook included information regarding physicians serving on hospital Boards of Trustees in Rhode Island and a *Pro and Con* discussion of the subject, *Doctors on Hospital Boards*, reprinted from the BULLETIN OF THE MEDICAL SOCIETY OF THE COUNTY OF NEW YORK. He stated that the material had been included purely for information purposes.

*continued on next page*



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*Miscellaneous Business*

The problem of how a physician may determine a patient's income when the patient is a subscriber under Physicians Service was discussed. Members of the House requested that the president of the Society seek to explore the question whereby physicians may secure accurate information on subscribers' incomes when a doubt exists regarding the declaration by the patient.

\* \* \*

Doctor Alexander Jaworski, of Pawtucket, spoke briefly on the subject of better relations between the Physicians Service staff and the physicians.

\* \* \*

Doctor Robert C. Hayes, reporting for the Health Insurance Committee, stated that the Committee urged the members to support the catastrophic hospital-nurse coverage and overhead expense program sponsored for the Society by the Committee. He also reported that his Committee has planned a meeting with the State Committee of the Health Insurance Council for the discussion of mutual problems of the insurance carriers and the Medical Society.

*Adjournment*

The House of Delegates was declared adjourned at 10:03 P.M.

Respectfully submitted,

THOMAS PERRY, JR., M.D., *Secretary*

\* \* \*

**REPORT OF THE SECRETARY**

The Council has held two meetings since the September session of the House of Delegates. Actions taken by the Council at these meetings included the following:

1. Doctor Stanley Sprague, chairman of the Committee on Industrial Health, was named the Society's delegate to the annual Congress on Industrial Health to be sponsored by the American Medical Association, and Doctor Earl F. Kelly the Society's official delegate to the Annual Congress on Medical Education and Licensure.
2. The Committee on Insurance was asked to review a proposal of the Council of the New England State Medical Societies regarding the feasibility of an investment and retirement program on a regional basis.
3. The president was authorized to name two delegates to a regional public health meeting at Worcester at which the problems of staphylococcal infections were to be discussed.
4. Doctor Richard P. Sexton, chairman of the Veterans Affairs Committee, was named the Society's delegate to a meeting called by the American Medical Association to discuss medical problems in caring for veterans.
5. The president was authorized to set a date for a special meeting of the House of Delegates to be held in December.

6. The president and other officers of the Society were established as a committee to review nominations for vacancies on the Medical Advisory Committee to the state Workmen's Compensation Commission.
7. The Executive Office was instructed to send out a committee service questionnaire to the membership of the Society.
8. Approval was given to the Insurance Committee to distribute for the Health Insurance Council a brochure relating to simplified claim forms for use by physicians.
9. The Committee on Group Professional Liability Insurance was authorized to take whatever steps necessary, with the aid of legal counsel, to effect a continuance of the Society's group program.
10. A Nominating Committee as authorized under the by-laws was appointed, consisting of Doctors Earl F. Kelly, Alfred L. Potter, Samuel Adelson, Henry E. Gauthier, and A. E. Hardy.
11. The Council went on record opposing treatment of private patients in a hospital clinic whereby the visiting physician is paid for the services rendered, and it voted that notice of this action be sent to each hospital.
12. The president was authorized to appoint a special committee to meet with committees of the Hospital Association, and the Blue Cross, to consider matters of mutual interest.
13. The appointments by the president of the Society's delegates to the annual meetings of neighboring state medical associations were approved.
14. The annual report of the treasurer was approved, and authorization made for the investment in the general investment fund of part of the surplus cash balance available at the end of 1958.
15. The reappointment of Doctor William A. Reid as liaison representative between the Society, the A.M.A. and the State's Congressional delegation was approved.
16. The secretary was instructed to notify the Governor of the State of the Society's great interest in the problems of medical care for persons over the age 65, and of its desire to participate actively in the State Conference on Aging.
17. The president was authorized to name the Society's representatives to the regional medico-legal conference to be held in Washington, D. C., March 20-21.
18. Doctor Charles J. Ashworth, president of Physicians Service, was authorized to represent the Society, also, if he attends a meeting of the Professional Relations Representatives to be held under the sponsorship of the Blue Shield Medical Care Plans in Chicago in February.
19. The Council approved of a proposal from the Committee on Scientific Work and Annual Meeting that the 1959 Interim Meeting be held early in September at a site outside Providence, if possible, but voted against the Committee's suggestion that the meeting be held on a Saturday, and expressed the opinion that a Wednesday would be preferable.
20. A report of the chairman of the Mental Health Committee on its 5th Annual Conference of Mental Health Representatives of State Medical Associations was received and recommended for publication in the RHODE ISLAND MEDICAL JOURNAL.
21. The Council rules that members of the Society who are career officers in the armed services, the Veterans Ad-



ministration of the Public Health Service, are subject to the full dues assessment annually.

22. The secretary was instructed to convey to the mayor of Providence the suggestion of the Council that the honorarium to the Charles V. Chapin orator given by the city be \$200 instead of \$100.

THOMAS PERRY, JR., M.D., *Secretary*

### *Report of the Treasurer*

The complete financial report for 1958 has been reviewed by the Council and approved. It will be subject to a professional audit in the coming month. Therefore a summary report is submitted below for the information of the House of Delegates.

We have combined the total financial assets of the Society and the accumulated assets of the Medical Journal, resulting in a cash balance at the end of the year of \$17,547.26, and cash accounts receivable of the Journal of \$1,285.93. This sum represents an accumulation of reserves over a period of years, and therefore the Council has voted that much of it be invested in the Society's investment account for future contingencies.

The budget for the year was closely adhered to, but unexpected expenses such as representation at special national conferences, including those with government officials relating to the Medicare program, together with the continued inflation as reflected in the increased cost of utility services, postage, etc., left the Society with a net over operating costs for the year of only \$616.23.

The investment account, representing general funds as well as special trusts willed to the Society, had a sizable increase in market value in 1958 due to the rise in value of the common stock portfolio.

A summary of the financial statement for 1958 is as follows:

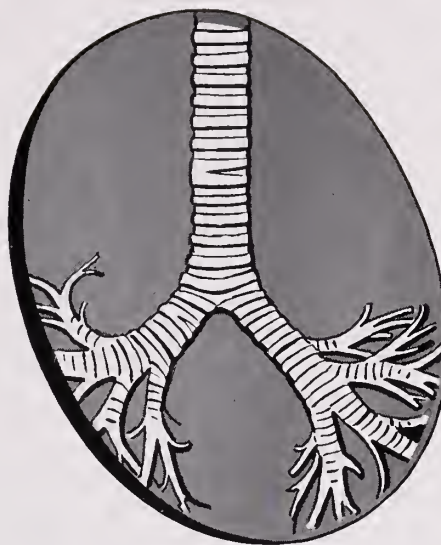
Cash balance, Checking Account, Industrial National Bank, January 1, 1958	\$ 18,183.66
Receipts, 1958 (all sources)	84,962.14
<b>TOTAL</b>	<b>\$103,145.80</b>
Expenses, 1958 (Society and Journal)	84,312.61
Cash balance, January 1, 1959	\$ 17,547.26
Journal accounts receivable	1,285.93
<b>CASH ASSETS</b>	<b>\$ 18,833.19</b>
Investments, General and Special Funds Trust Department Industrial National Bank Market Values	62,314.00
<b>TOTAL ASSETS</b>	<b>\$ 81,147.19</b>

FRANCIS V. GARSIDE, M.D., *Treasurer*

### **RHODE ISLAND MEDICAL SOCIETY BENEVOLENCE FUND**

In 1958 the trustees of the Benevolence Fund extended financial assistance to four physicians and

*continued on next page*



*prescribe*

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*for continuous control  
of bronchospasm in*

## CHRONIC ASTHMA

Whether for a sudden attack or for prolonged therapy, ISOPHYLLIN brings emergency help plus 'round-the-clock relief to the chronic asthmatic.

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their families, and in addition provided them with family coverages in Blue Cross and Physicians Service. In each instance the physician was disabled and unable to engage in medical practice.

During the year the Fund received a total of \$2,892.00 in contributions. This sum, plus the cash reserve at the start of the year and interest, resulted in total assets of \$6,107.54, from which \$2,116.40 was paid out in benefits, leaving a cash balance at the start of 1959 of \$3,991.14.

In June, 1958, the U. S. Treasury Department ruled the Fund exempt from tax since it is organized and operated exclusively for charitable purposes. Thus contributions to it may be deducted on personal tax returns by the donors.

The trustees acknowledge in particular the active support of the Fund by direct solicitation of members by the Providence Medical Association, the Washington County Medical Society, the Woonsocket District Medical Society, and the Women's Auxiliary of the Society.

The financial report for 1958 is as follows:

Cash balance, Savings Department, Industrial Nat'l Bank, in Providence, January 1, 1958	\$3,091.24
Receipts, 1958	2,892.00
Interest on Savings Account	124.30
<i>Total Assets</i>	<i>\$6,107.54</i>
Benefits paid out in 1958—Cash	\$1,700.00
Blue Cross-Physicians Service Coverage	416.40
	<i>2,116.40</i>
Cash Balance, Savings Department Industrial Nat'l Bank, Jan. 1, 1959	\$3,991.14
Respectively submitted, DAVID FREEDMAN, M.D. HENRY J. HANLEY, M.D. GEORGE W. WATERMAN, M.D. <i>Trustees of the Benevolence Fund</i>	

### CANCER COMMITTEE

The Cancer Committee of the Rhode Island Medical Society has arranged for the presentation of the Annual Cancer Conference, Wednesday, March 18, 1959. The program will be presented by a group from the Roswell Park Memorial Institute, Buffalo, New York, and is as follows: Doctor John Parsons: *Radiotherapy in Cancer*; Doctor John Graham: *Some Aspects of Neoplasms of the Genital Tract*; Doctor James Holland: *Cancer Chemotherapy*; Doctor James Grace: *Immunological Aspects of Cancer and Cancer of the Gastrointestinal Tract*.

HERBERT FANGER, M.D., *Chairman*

### MATERNAL HEALTH COMMITTEE

On the evening of December 9, 1958, this Committee met at the home of Doctor John Walsh. The maternal deaths for the latter half of the year were reviewed, but inasmuch as two more deaths have occurred since the meeting, we will be unable at this time to give a final report of the year's mortality statistics.

In our report one year ago, mention was made of the need of a perinatal mortality committee in Rhode Island, but no definite action was taken. At this meeting, this subject was again discussed and a committee was appointed to study the possibilities of and help promote the formation of such a committee of the Rhode Island Medical Society. Doctor Bertram Buxton was appointed as chairman with Doctor William J. MacDonald, Doctor William Reid, and Doctor George W. Anderson to assist him. We are fortunate now to have with us in Rhode Island Doctor Anderson, formerly of the Johns Hopkins Hospital, who is nationally known for his studies on the subject of perinatal mortality.

Our Maternal Health Committee in the past has been chiefly concerned with the study of maternal deaths. However, in the past two decades, maternal mortality has decreased by more than 90% and many of the deaths now are due to rare and bizarre causes which are not preventable. There has not been a similar reduction of fetal or neonatal deaths during this same period, even though our improved maternal care should help reduce the perinatal mortality rate. Many cities, counties, and even some states throughout the country have had such committees functioning for several years. Ours is a small state with a concentrated population, and it should be quite easy to conduct such studies.

It is sincerely hoped that the Society will see the need of the formation of a perinatal mortality committee in Rhode Island. It would have to include pediatricians as well as obstetricians and probably others such as a pathologist and anesthetist and, therefore, should be a separate committee from the Maternal Health Committee.

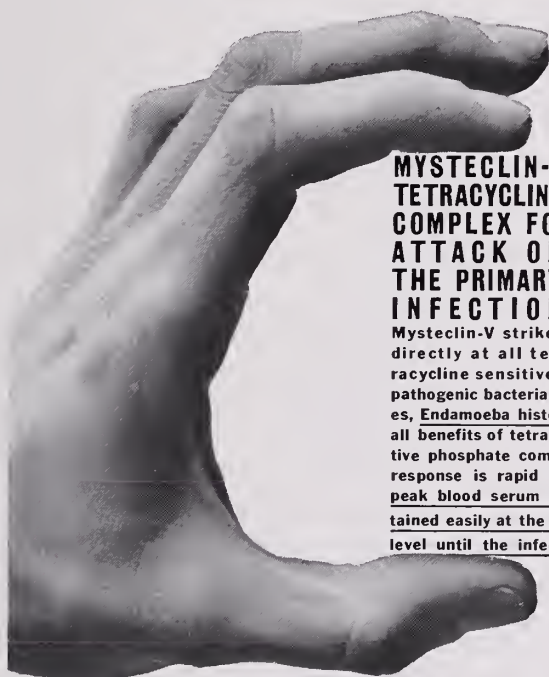
STANLEY D. DAVIES, M.D., *Chairman*

### MENTAL HEALTH

The Committee on Mental Health met on January 15, 1959. The principal topic on the agenda had to do with giving direction and emphasis in our thinking on the problems arising in the old age group. There is such a welter of opinions and perspectives with respect to this timely but often sentimentally approached problem. Doctor Ezra Sharp is the chairman of the Committee on Aging of the Rhode Island Medical Society. On very short notice, and with much graciousness, Doctor Sharp attended our Committee meeting. The interchange and communication was helpful.

*concluded on page 204*

more than tetracycline alone



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TETRACYCLINE PHOSPHATE  
COMPLEX FOR A DIRECT  
ATTACK ON  
THE PRIMARY  
INFECTION**

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**Half-strength Capsules** (125 mg./125,000 u), bottles of 16 and 100.

**Suspension** (125 mg./125,000 u per 5 cc.), 2 oz. bottles.

**Pediatric Drops** (100 mg./100,000 u per cc.), 10 cc. dropper bottles.

**References:** 1. Crunk, G. A.; Naumann, D. E., and Casson, K.: *Antibiotics Annual 1957-1958*, New York, Medical Encyclopedia Inc. 1958, p. 397.  
2. Newcomer, V. D.; Wright, E. T., and Sternberg, T. H.: *Antibiotics Annual 1954-1955*, New York, Medical Encyclopedia Inc., 1955, p. 686.

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# MENTAL HEALTH COMMITTEE

*concluded from page 202*

With the objective of giving direction and emphasis to energies expended in alleviating this problem, the Committee on Mental Health would like to make the following points:

There is a natural old age. The majority of people capably meet this aspect of their total life. Disregard of this fact leads to distortion in approaching the problem. Physicians, social workers and social agencies see a disproportionately high number of older people who for various reasons are prevented from functioning in accordance with natural old age. One of the prerequisites for meeting old age naturally is an intact central nervous system. The central nervous system is the integrating and coordinating system of the body. If pathological old age has made inroads on the central nervous system then meeting old age naturally is thwarted and this thwarting is greater than when any other body system becomes pathological. It follows that a direction of effort in alleviating the old age problem is for medicine to develop the capacity to keep the central nervous system intact.

There is another point that the Committee on Mental Health would make. History tells us that different generations of people are faced with different problems. Much of the magnitude of the problem of old age has been constructed from those

# RHODE ISLAND MEDICAL JOURNAL

people born from the 1870's to the 1890's. These generations, when still young people, had a tendency to look with apprehensiveness toward the coming of old age. There have been many happenings which it is confidentially believed will result in the generations born after 1900 approaching the fact of old age quite differently. To cite just one happening: Changes in communication make it possible for the person in the old age group to continue to relate to present-day happenings with ease. Travel as a form of communication is within the realm of the older individual whereas to the generations from the 70's to the 90's a trip in a horse and buggy would have been prohibited. This tremendous change in communication enables the person with an aging body to remain in contact with the stream of living as has never previously been possible. A position by the fireside, patiently awaiting the end of his life, is not a requirement in the present-day world.

Finally the Committee would call your attention to the frequent use of the word "need" in relationship to many problems pertaining to health and welfare on today's scene. The semantics of this word should be studied.

The Committee on Mental Health emphasized these points with the intent of aiding and clarifying the thinking of the House of Delegates.

HAROLD W. WILLIAMS, M.D., *Chairman*

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## DISTRICT MEDICAL SOCIETY MEETING

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### PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, February 2, 1959. The meeting was called to order by the president, Doctor John C. Ham, at 8:30 P.M.

#### *Minutes of the Previous Meeting*

The minutes of the previous meeting of the Association were not read. The president noted that the minutes would be published in the RHODE ISLAND MEDICAL JOURNAL.

#### *Communications*

Doctor Michael DiMaio, secretary, read a communication from Rhode Island Hospital announcing that Doctor Chester M. Jones, Professor of Clinical Medicine, *Emeritus*, at Harvard Medical School, would serve as Physician-in-Chief *pro tempore* at the Hospital on February 16, 17 and 18.

#### *Committee Appointments*

Doctor John C. Ham read the list of appointments he had made to serve on the various committees of the Association for the year 1959.

#### *Obituary*

The president announced that on January 3 the Association had lost by death Doctor Israel Kapnick, of Providence. He stated that an expression of sympathy had been extended to Doctor Kapnick's family from the Association, and he asked that the members present at the meeting stand for a moment of prayer.

#### *Scientific Program*

The president introduced Doctor Samuel D. Clark, formerly of Bristol, Rhode Island, and now physician, Medical Department; Medical Officer, Radioactivity Center, Massachusetts Institute of Technology, Boston, Massachusetts. Doctor Clark, speaking on the subject, *The Watches That Won't Run Down*, reported on the results of investigations of victims of radium poisoning after an interval of thirty years.

During the years 1925-1927, radium workers applied radium to watch dials with a small brush. Between applications of the material, the workers would moisten the brushes with their lips and it was in this manner that they were repeatedly exposed to radium and radium poisoning.

The speaker noted that gamma radiation was not

dangerous because it is not stored in the body. Alpha radiation, on the other hand, was very dangerous because it produced radiation year after year for a lifetime.

Doctor Clark pointed out that osteogenic sarcoma and carcinoma of the paranasal sinuses were commonly produced by repeated exposure to radium as described.

#### *Adjournment*

The meeting was adjourned at 9:50 P.M.

Attendance was 78.

Collation was served.

Respectfully submitted,

MICHAEL DIMAIO, M.D., *Secretary*

### NECROLOGY — 1958\*

JAMES H. MCCOOEY, M.D., a leading citizen of Woonsocket whose medical-political career spanned half a century, died at his home on June 30, 1958, at the age of seventy-four.

Doctor McCooey was a graduate of the Baltimore College of Physicians and Surgeons (now the University of Maryland Medical School) which honored him in 1957 as a fifty-year alumnus. He passed the state examining board medical examinations in 1906 in both Rhode Island and Massachusetts, and he maintained offices for many years in Millville and Blackstone. In 1918, he opened his Woonsocket office where he practiced until his retirement in 1951.

He was a past president of the Woonsocket Hospital, a past president of the Woonsocket District Medical Society, and an active member of both the Rhode Island Medical Society and the American Medical Association.

Active in politics nearly all his life, Doctor McCooey served as a selectman, as chairman of the Blackstone Valley River Authority, as administrator for the WPA and PWA, as town moderator, and as chairman of the Democratic Town committee, a post he held from 1936 until his final illness.

His survivors include four sons, Dr. James H. McCooey, Jr., of North Smithfield, Dr. Thomas S. McCooey, John G. McCooey, and Alfred E. McCooey, all of Blackstone; two daughters, Mrs. Ralph E. Erb of Roslyn, N. Y., and Mrs. Matthew F. Sullivan of Blackstone.

(\*The Editors regret that this Necrology listing was not included in the January issue.)



# REACHING FOR THOSE 9B's NEARLY PUT ME ON THE SHELF...

## Percodan®-Demi & Percodan® Tablets Salts of Dihydrohydroxycodone and Homatropine, plus APC *FOR PAIN*

**ACTS FASTER** — usually within 5-15 minutes.  
**LASTS LONGER** — usually 6 hours or more. **MORE THOROUGH RELIEF** — permits uninterrupted sleep through the night. **RARELY CONSTIPATES** — excellent for chronic or bedridden patients. **VERSATILE** — new "demi" strength permits dosage flexibility to meet each patient's specific needs. **PERCODAN-DEMI** provides the **PERCODAN** formula with one-half the amount of salts of dihydrohydroxycodone and homatropine.

**AVERAGE ADULT DOSE:** 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

Each **PERCODAN®** Tablet contains 4.50 mg. dihydrohydroxycodone hydrochloride, 0.38 mg. dihydrohydroxycodone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

**AND THE PAIN  
WENT AWAY FAST**



Literature? Write  
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Reaching for 9B shoes and other top shelf sizes is no joke... it gave me a terrible kink in my back.



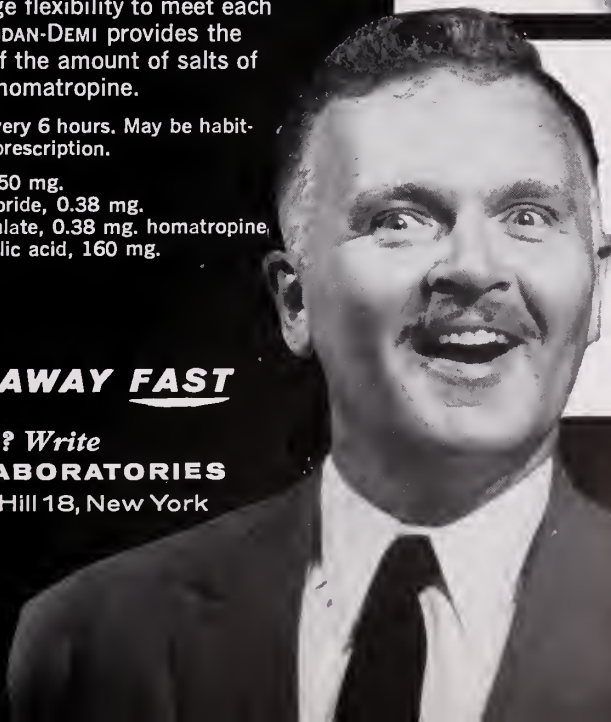
Before the day was over, I could hardly stoop to push a shoehorn.



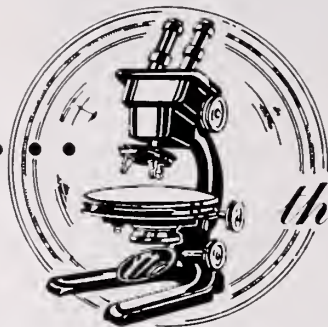
I called my doctor that night and picked up the tablets he prescribed.



The pain went away fast—in just 15 minutes—and I was back on the job the next morning! But not one 9B customer came in the whole day!



## THROUGH .

*the Microscope*

### ***Doctor Draft Bill Extended By House of Representatives***

The House Armed Services Committee recently cleared legislation for a four-year extension of the regular draft act and with it the doctor draft, and sent the bill to the House for action. Without an extension both provisions would expire next June 20.

Under the act doctors who have obtained an educational deferment are subject to call up to age 35, whereas other registrants are free of obligation after age 26. The A.M.A. maintains that physicians should be registered and classified in the same manner, and called to duty "under the same general provisions as other registrants deferred for educational purposes."

### ***Study to be Made of Rhode Island Facilities for Chronically Ill and Aged***

The Rhode Island Council of Community Services is to receive a \$12,000 U.S. Public Health Service grant annually for three years, plus \$1,800 from the Rhode Island Foundation, to test the potential of a central information, referral and consultation service to chronically ill and aging persons in the state for better use of existing services, identifying gaps in services, and designing new patterns of service.

When the project is established it will be possible for any person to obtain information by telephone on health, welfare and recreation services available to meet their needs.

### ***\*They're Stealing My Dollars, Robbing My Children, Grandchildren, and Great-Grandchildren***

Mr. Hoffman of Michigan. Mr. Speaker, my parents and my grandparents never had a dollar they did not earn through manual labor—except what the latter left to the former.

Whatever the grandparents, by practicing thrift,

\*EXTENSION OF REMARKS of CLARE E. HOFFMAN, of Michigan, in the House of Representatives, Monday, January 26, 1959.

*Congressional Record*, Jan. 26, 1959

were able to save, they gave to my parents. My parents lived simply, frugally, and one of the principal objectives of their toil and their thrift was to give my sister and me a better start in life than they enjoyed.

The wife and I have been endeavoring, throughout our 59 years of married life, to follow along the same path. From time to time, out of my earnings as a lawyer and because of our frugal living, we were able to purchase a little life insurance, a few securities, put a little money in the bank, buy a home and a little additional real estate; but, for the last 20 years, the purchasing power of our investments—except those in real estate—has been shrinking. And the taxes on the real estate have become so high that it no longer pays its way, returns a profit. Nor has the actual purchasing value of real estate—except in development instances—increased.

The result is that, because—as the days roll by—the purchasing power of his resources is less than when he denied himself, attempted to securely invest any surplus, there is today little inducement for the average citizen to work, attempt to practice thrift, to accumulate property or a bank account.

### ***Why Do Twenty Million Americans — or One Out of Every Eight — Enter a Hospital Each Year?***

This is the subject of a \$200,000 study just authorized by the Executive Committee of Health Information Foundation. It will be conducted jointly by the National Opinion Research Center of the University of Chicago and the Foundation.

A sample of admissions to hospitals in Massachusetts will be examined through the approval and co-operation of the Massachusetts Medical Society, the Massachusetts Hospital Association and the Blue Cross-Blue Shield Plans in that state. The two and one-half-year study will attempt to ascertain the non-medical factors and family situations which lead to hospital utilization as well as medical reasons given by physicians.

*concluded on page 212*

## SPECIAL SERVICE FOR DOCTORS

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A 1959  
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**LINCOLNS • CADILLACS  
IMPERIALS**

any make – any model  
– any color

**YOU PAY** Only for Gas Used

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erated. Its extended duration insures greater  
postoperative comfort for the patient. Its  
potency and diffusibility render reinjec-  
tion virtually unnecessary. It may be in-  
filtrated through cut surfaces permitting  
pain-free exploration and longer suturing time.



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sies; tying superficial varicose veins; minor rectal surgery; simple frac-  
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TABLET  
DAILY**



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Highly soluble in acid and alkaline media . . . rapidly absorbed, producing fast, effective plasma-tissue concentrations sustained for the entire day. Simple, single 0.5 Gm. daily dose minimizes patient dosage confusion. At least equivalent to 4 to 6 Gms. daily of previous sulfonamides. Does not produce renal complications.<sup>1</sup>

**with low incidence of sensitivity reactions . . .**

KYNEX is extremely low in toxic potential.<sup>2,3</sup>

Cutaneous or other objective sensitivity reactions are rare, as demonstrated in a large scale evaluation of clinical toxicity.<sup>2</sup> Also minor subjective reactions are less likely to develop when the recommended dosage is used.<sup>2</sup>

Dosage: Adults, 0.5 Gm. (1 tablet) daily following an initial first-day dose of 1 Gm. (2 tablets).

TABLETS, 0.5 Gm. Bottles of 24 and 100.

also available — KYNEX Acetyl Pediatric Suspension, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.). Bottles of 4 and 16 fl. oz.

1. Editorial, New England J. Med. 258:48, 1958.

2. Vinnicombe, J.: Antibiotic Med & Clin. Ther. 5:474, 1958.

3. Sheth, U. K., et al.: Ibid., p. 604, 1958

**for improved control  
WHENEVER SULFAS ARE INDICATED**

# KYNEX<sup>®</sup>

Sulfamethoxypyridazine Lederle



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## THROUGH THE MICROSCOPE

*concluded from page 208****One New Case Every Five Minutes***

Tuberculosis as a cause of death has dropped from first to thirteenth place in the past half century, but one new case is reported every five minutes in the United States.

This fact is revealed in the current issue of *PATTERNS OF DISEASE*, prepared by Parke, Davis & Company for the medical profession.

In the past twenty years alone the number of tuberculosis deaths has dropped about 80 per cent. The number of newly reported cases, however, has declined only about 20 per cent during this period.

This publication stresses the need for more intensive drives to detect the disease. For every known case, it reports, there is one unknown tuberculous person. Total number of known and unknown cases (both active and inactive TB) in the U.S. is estimated at 800,000.

"To eradicate tuberculosis," *Patterns* points out, "the disease must be detected and treated early, while lesions are small and readily amenable to therapy." Yet, for the past five years, only about 22 per cent of newly reported active and probably active cases have been in the early stage. In 1956, about 20 per cent of persons who died of tuberculosis had not been previously reported as having the disease.

***Surgeons to Hold Sectional Meeting in Montreal in April***

The American College of Surgeons will hold its first Canadian four-day Sectional Meeting in Montreal, for surgeons and nurses, April 6-9. Headquarters will be the Queen Elizabeth Hotel, with many sessions scheduled at leading Montreal hospitals.

This four-day meeting, like the annual Clinical Congress, is designed to inform the medical profession at large about developments in surgery, and to focus attention on newer ways of handling problems encountered in daily practice. The program will include hospital clinics, panel discussions, symposia, scientific papers, technical exhibits, medical motion pictures and cine clinics in general surgery and the surgical specialties of anesthesiology, ophthalmic surgery, otolaryngology, urology, orthopedic surgery, and gynecology-obstetrics.

***An Estimated 121 Million Americans Have Health Insurance***

By the end of 1958, health insurance protected an estimated 121 million Americans against the cost of hospital and doctor bills, the Health Insurance Institute has reported in a review of the year.

The number of persons covered by health insurance through insurance company programs, Blue Cross-Blue Shield and other plans represents 70% of the population.

Reports from the 700 insurance companies handling health insurance in the U.S. disclosed substantial progress was made last year in providing sound programs for persons over age 65. Gains in coverage were also noted for the individual and family policyholder, employees of small business firms and for people living in rural areas.

***Top Priority to Basic Medical Research Programs Urged***

Declaring that in modern medicine it is basic knowledge that needs to be increased "as rapidly as possible," the nation's drug manufacturers recently urged the government to give top priority to basic medical research programs.

In a 1000-word Statement of Principle, the Pharmaceutical Manufacturers Association warned that the U.S. faces a 25 per cent deficit in the number of medical scientists needed by 1970. Therefore, the association said, the government must also give highest priority to programs which would lead to the training of additional teachers and researchers.

The P.M.A. said that pharmaceutical industry laboratories should not receive government subsidies except for those "exceptional cases" in which U.S. agencies cannot find a nonprofit institution capable of turning out the required research. As a matter of fact, the P.M.A. declared, research subsidies to drug firms rather than to academic institutions would probably result in further depletion of an already dwindling supply of scientists in nonprofit centers.

***Acute Illnesses Highest in Youngest Age Groups***

About 438 million acute illnesses involving either restricted activity or medical attention or both occurred among the American people during the year ending June 30, 1958. The number of such illnesses averaged 2.6 for every person in the population.

The figures are from the newest report of the U.S. National Health Survey, which shows also that the incidence was highest in the youngest age groups and decreased progressively in each older age group. The rates ranged from an average of 4 illnesses among children under 5 to 1.6 illnesses per person 65 or over.

The incidence rate among females was slightly higher than for males.

Respiratory ailments accounted for 65 per cent of all the illness involving medical attention or restricted activity. The respiratory illnesses caused 1,172 million days of restricted activity, or an average of 7 days per person. About half of this time involved bed disability.

The days of restricted activity included 219 million days lost from work, and 196 million days lost from school. The incidence of these illnesses reflects the impact of the Asian influenza epidemic which occurred during the year.





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## BOOK REVIEWS

*OUR NUCLEAR ADVENTURE: Its Possibilities and Perils* by D. G. Arnott, Philosophical Library, New York, 1958.

This volume has four major divisions in which the author has tried to present the basic concepts of atomic dynamics, to consider the frightening danger of co-annihilation, to speculate on the limitless benefits to be derived from the industrial application of atomic power and thermonuclear power, and to shock the reader into awareness of his responsibilities in living with "the nucleus."

In assuming that the reader has no knowledge of atomic theory or the phenomenon of radioactivity, Mr. Arnott has been able to present a very clear and concise picture of nuclear anatomy. This groundwork gives one the courage to try to decipher some of his rather enigmatic descriptions of fission-fusion-fission bombs and nuclear reactors. In his presentation the author has oversimplified and in some cases omitted important details. Consequently, other sources are necessary for a clear understanding.

Especially interesting are his chapters on immediate and long-term fallout. He discusses many facets of the fallout problem—the experience of the Japanese following the 1954 Bikini explosion, the non-uniformity of the distribution of radioactivity due to variation of toxicity of the elements used by different nations, and the contamination of fish by sea currents originating in test areas. Although the author cites many of the benefits contingent on the control of atomic power, he does not lose sight of such problems as the storage of fissionable materials and the disposal of waste products from atomic reactions. Also of a sobering nature are the effects which Arnott feels the increased amounts of radiation will have on heredity and the more immediate dangers such as sterility, myeloid leukemia and aplastic anemia. This book has been written to reawaken "ordinary man" to the "fact" that he has alienated himself "from any semblance of control over his own destiny" and that this "is one of the great dangers of our age." This intention has certainly been achieved by the author's less than optimistic tone. Whether or not you agree with Mr. Arnott's philosophical thesis, *OUR NUCLEAR ADVENTURE* is for the most part interesting reading.

JOANN K. WATSON

*THE DOCTOR BUSINESS* by Richard Carter. Doubleday & Co., Garden City, N.Y., 1958. \$4.00

This is a book that, according to its publisher "pulls back the curtain that hides the commercial side of your doctor's practice and of organized medicine in America."

Actually it is an attempt by a news reporter turned writer—to make a strong case for Closed Panel Group Practice.

Typical of news reporters, he sets up a predetermined objective and then proceeds to develop his thesis by using sundry situations, quotations, incidents and philosophies to support it.

Although the author writes interestingly enough in the first part of his book he soon lapses into dull reporting of events and ends with statistics and a list of the member clinics of Group Health Federation of America.

The shortcomings of some doctors, and the A.M.A. are emphasized. Fee-for-service is condemned as archaic. The author believes that social control is the only way to insure public health with the elimination of the fee basis to early diagnosis. He espouses a consumer-physician-government agency to "guide the choice of a physician and to supervise the cost and adequacy of services."

The author states that the responsibility for the book is his own. Nevertheless he obviously has the support and approval of Group Health Federation, inasmuch as a recent issue of their *News Letter* praised the book and promised an early review of it by Doctor James Howard Means.

I may surprise my colleagues, but I recommend this book to all doctors at the policy-making level of state and county medical societies, and urge them to read it. It is important to know what others think and say about us even if they are biased and partial.

CHARLES L. FARRELL, M.D.

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APRIL, 1959

## *Medical Journal*

*148th Annual Meeting  
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Society  
May 12 and 13, 1959  
... See page 276*

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**REFERENCES**—(1) Glazko, A. J., *et al.*, in Welch, H., & Marti-Ibañez, E.: *Antibiotics Annual 1957-1958*, New York, Medical Encyclopedia, Inc., 1958, p. 792. (2) Unpublished data: Research Laboratories, Parke, Davis & Company, 1958. (3) Ross, S.; Puig, J. R., & Zarenba, E. A., in Welch, H., & Marti-Ibañez, E.: *Antibiotics Annual 1957-1958*, New York, Medical Encyclopedia, Inc., 1958, p. 803. (4) Payne, H. M., & Hackney, R. L., Jr.: *ibid.*, p. 821. (5) McCrumb, F. R., Jr.; Snyder, M. J., & Hicken, W. J.: *ibid.*, p. 837.

#### TYPICAL CLINICAL EXPERIENCE WITH CHLOROMYCETIN SUCCINATE

Type of infection	RESULTS			
	Number of Patients	Excellent to Good	Fair	Poor
Respiratory <sup>3,4,5</sup>	32	32		
<i>Shigella</i> dysentery <sup>2</sup>	14	14		
Enteritis <sup>2</sup>	10	6	2	2
Bacteremia <sup>3,5</sup>	5	5		
Meningitis <sup>3,5</sup>	4	3		1**
Rocky Mountain spotted fever <sup>3,5</sup>	2	2		
Ear abscess with cellulitis <sup>1</sup>	1	1		
Lung abscess <sup>1</sup>	1			1
Typhoid fever <sup>5</sup>	1	1		
TOTALS	70	64	2	4

\*Includes 15 patients who were administered CHLOROMYCETIN SUCCINATE by nebulization under intermittent positive pressure breathing.

\*\*Patient was hydrocephalic at birth; cerebrospinal fluid was sterile at time of death.

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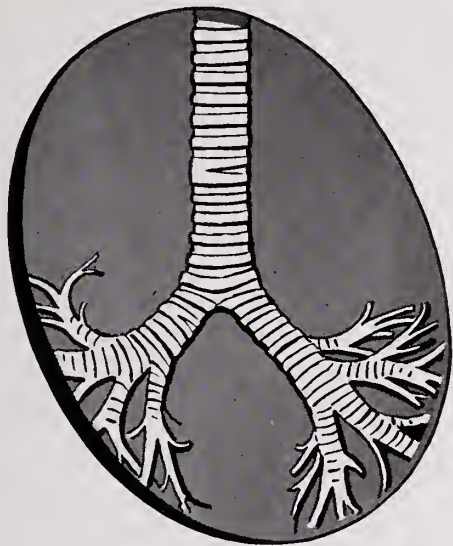
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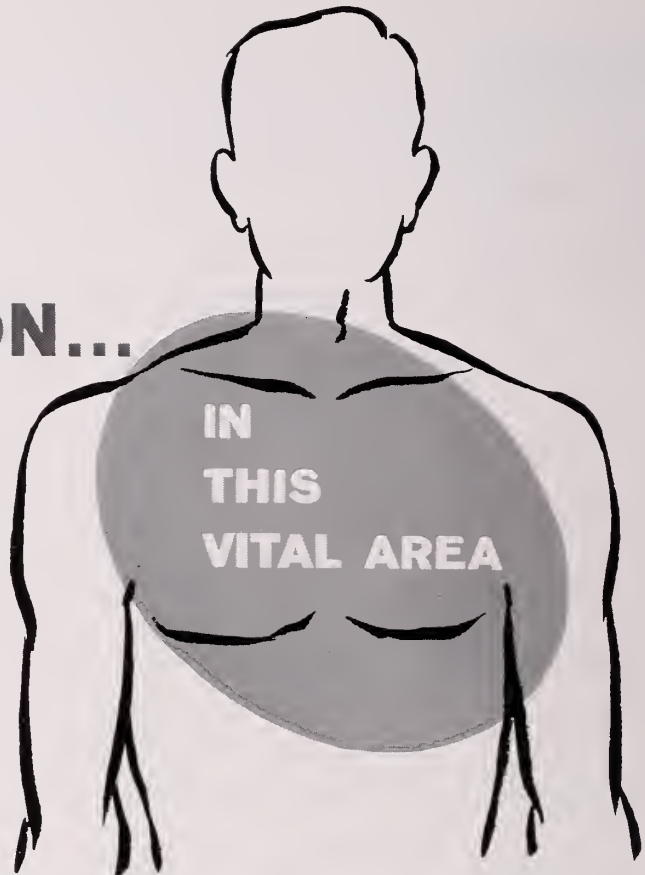
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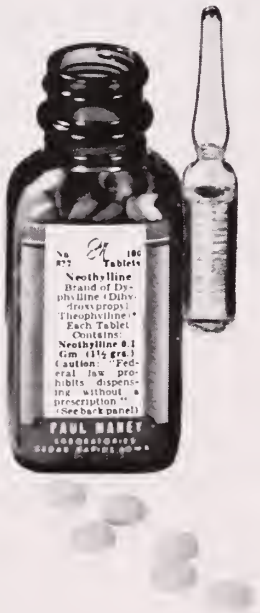
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Baccaredda Boy, A., and Cappelli, E.: Clinical study of the activity of a new antibiotic preparation, Signemycin, in skin conditions of infectious (pyogenous) origin, *Minerva med.* 48:2690 (Aug. 25) 1957. 7. Bergdahl, U.: Clinical experiences with a so-called double-spectrum antibiotic, Signemycin, *Svenska Lakartidningen* 55:1715, 1958. 8. Blundi, E.: Use of Signemycin in a chest clinic, to be published. 9. Bolognesi, C.: Preliminary results of the use of Signemycin in certain otorhinolaryngological infections due to pyogenic organisms, *Minerva med.* 48:2693 (Aug. 25) 1957. 10. Brodhage, H.: Bakteriologische in-vitro-versuche mit einer kombination von tetracyclin und oleandomycin (Signemycin), *Praxis* 26:579, 1957. 11. Calvi, A.: Antibiotics in the therapy of influenza and its pulmonary complications, to be published. 12. Carter, C. H., and Maley, M. C.: Application of tetracycline-oleandomycin in clinical practice, *Antibiotics Annual* 1956-57, New York, Medical Encyclopedia, Inc., 1957, p. 51. 13. Castellanos, A.: Signemycin in pediatrics, to be published. 14. Chiappara, P.: A case of sepsis with multiple osteomyelitis treated with a new antibiotic, *Minerva med.* 48:2697 (Aug. 25) 1957. 15. Chiarenza, A.: Observations on the effects of Signemycin in nongonococcal urethritis, *Minerva med.* 48:2692 (Aug. 25) 1957. 16. Cimmino, A.; Boni, A., and Orsi, N.: Antibiotic activity of oleandomycin-tetracycline combination, *In vitro* study on 332 strains of *Micrococcus pyogenes* var. *aureus* clinically isolated, *Antibiotics Annual* 1957-1958, New York, Medical Encyclopedia, Inc., 1958, pp. 708-715. 17. Cooper, J.; Sprogis, G. R.; Heinemann, M., and Feirer, G. M.: Therapy of amebiasis carriers with oleandomycin-tetracycline (Signemycin), *Antibiotic M.* 5:302 (May) 1958. 18. Cornbleet, T., and Firestein, B. Z.: Use of oleandomycin-tetracycline (Signemycin) for acne, *Antibiotic M.* 4:598 (Oct.) 1957. 19. Cupples, J. F. B., and Perry, A. W.: Acute staphylococcal endocarditis treated with tetracycline-oleandomycin successfully, *Canad. M. Assoc. J.* 77:699 (Oct.) 1957. 20. Davis, W. G.: Report on tetracycline and oleandomycin used in combination, *Clinical Review & Research Notes*, 1:21-23 (April) 1958. 21. DeRomana, J.; Zaldivar, C., and Falcone, F.: Actual therapeutic conduct in the treatment of osteomyelitis, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 1958, to be published. 22. Durrieu, C. A.; Rodriguez, J. B., and Petrella, E.: The use of oleandomycin-tetracycline in buccal surgery, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 1958, to be published. 23. English, A. R.; McBride, T. J.; Van Halsema, G., and Carlozzi, M.: Biologic studies on PA-775, a combination of tetracycline and oleandomycin with synergistic activity, *Antib. & Chemo.* 6:511-522 (Aug.) 1956. 24. Farah, L.: Some therapeutic indications of Signemycin, *Medicina*, Mex. 783:519 (Nov.) 1957. 25. Faz Tabio, H.: Severe enterosepsis treated with Signemycin, *Rev. cubana pediat.* 29:3 (May) 1957. 26. Faz Tabio, H.: Signemycin in the treatment of certain diseases of the respiratory tract, *Rev. cubana pediat.* 30:219 (Apr.) 1958. 27. Febles, D., and Biderman, L.: Antibiotic management of acute infections in the obstetric patient, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 1958, to be published. 28. Felder, J.: Signemycin in der pediatrie, *Schweiz. med. Wschr.* 88:953 (Sept. 27) 1958. 29. Fiora, F., and Compa, F.: The combination antibiotic oleandomycin-tetracycline (Signemycin) in acute blennorrhagia, *Dia med.*, B. Air, 30:570 (Apr. 3) 1958. 30. Florio, L., and Scopetta, F. P.: Sigamycin ed occlusione intestinale sperimentale, *Bulletin med. & surg. soc.*, Pavia, 71:1, 1957. 31. Foradori, M.: A case of meningitis due to *Staphylococcus aureus* complicating tubercular meningitis, treated successfully with Signemycin, *Minerva med.* 48:2707 (Aug. 25) 1957. 32. Frank, L., and Stritzler, C.: Newer antibiotics in the treatment of acne, *Antibiotic M.* 4:419 (July) 1957. 33. Friedrich, K., and Hammerl, H.: A new treatment for bacterial infection with an antibiotic combination, to be published. 34. Gemma, G. B.; Mel, C., and Bachi, V.: First experiences with Signemycin in surgical infections, *Minerva med.* 48:2643 (Aug. 25) 1957. 35. Gilley, E. W.: Clinical appraisal of tetracycline and oleandomycin used in combination, to be published. 36. Hagan, H., and Scheffler, H.: Preliminary clinical experience with oleandomycin and the double-spectrum antibiotic, Signemycin, *Medizinische*, 14:477 (Apr. 6) 1957. 37. Harris, H. J.: Tetracycline and oleandomycin (Signemycin) in chronic brucellosis, to be published. 38. Hasenclever, H. F.: Comparative *in vitro* studies of hospital strains of *Staphylococcus aureus* with oleandomycin, tetracycline and an oleandomycin-tetracycline mixture, *Antibiotic M.* 5:14-25 (Jan.) 1958. 39. Heglin, R.: Ornithosis, *Schweiz. med. Wschr.* 3:64, 1958. 40. Henne, H. F.: Clinical experiences with the double-spectrum antibiotic Signemycin, *Med. Klin.*, Berl., 29:1267-1270 (July 18) 1958. 41. Heredia Diaz, J.; Saavedra Zavaleta, G.; Robles, M. A., and Aguilar, D. L.: Tetracycline-oleandomycin (Signemycin) in the treatment of puerperal infections, *Medicina*, Mex. 38:308, 1958. 42. Hoffmann, H.: Clinical experiences with the broad-spectrum antibiotic, Signemycin, *Medizinische*, 45:1850 (Nov. 8) 1958. 43. Hoz Fabra, J.: Preliminary results of a clinical trial with Signemycin, *Rev. clin. espan.* 67:101 (Oct. 31) 1957. 44. Kaiser, J. A.; Mazzarino, C.; Bajek, E. M., and P'an, S. Y.: Oleandomycin-tetracycline: Toxicity in experimental animals, *Antibiotics & Chemother.* 7:255-259 (May) 1957. 45. Kance, B., and Cockcroft, W. H.: Clinical and bacteriological studies on Signemycin (oleandomycin-tetracycline) ointment, *Canad. M. Assoc. J.* 78:614 (Apr. 15) 1958. 46. Keil, P. G.; Tieszen, R. L., and Solomon, R. J.: An evaluation of Signemycin in the treatment of pneumonia, to be published. 47. Klovstad, O.: Signemycin "Pfizer" a combination of oleandomycin and tetracycline, *Tidsskr. norske lægefor* 15:681 (Aug.) 1957. 48. Kohler, H. F.: Case report of the month: chronic osteomyelitis, *Clinical Review & Research Notes*, 1:16 (Apr.) 1958. 49. Kraljevic, R., et al.: Investigation of the therapeutic value of the combination of tetracycline and oleandomycin, *Antibiotic M.* 5:364-371 (June) 1958. 50. Kraljevic, R.: Discussion of the paper by Florentin and Sison (The role of antibiotics in Asian Influenza), *Antibiotics Annual* 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 948. 51. Kraljevic, R.; Pearson, E., and Borgano, J. M.: Combined oleandomycin-tetracycline therapy in respiratory tract and other infections, to be published. 52. LaCaille, R. A., and Prigot, A.: Combinations of oleandomycin with oxytetracycline and tetracycline in soft-tissue infections, *Antibiotics Annual* 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 67. 53. Levi, W. M., and Kredel, F. E.: A clinical trial of Signemycin, *South Carolina M. J.* 53:178 (May) 1957. 54. Lewis, H. M.; Frumess, G. M., and Henschel, E. J.: Treatment of skin infections with tetracycline and oleandomycin, *Rocky Mountain M. J.* 54:806 (Aug.) 1957. 55. Lopez, A. V., and Cohen, H. J.: The clinical trial of a combination of tetracycline hydrochloride and oleandomycin (oral suspension) in the treatment of severe pulmonary infections in children, to be published. 56. Loughlin, E. H., and Mullin, W. G.: Combined antibiotic therapy of tropical infections with Matrotetra and Signemycin, *Antibiotics Annual* 1957-58, New York, Medical Encyclopedia, Inc., 1958, p. 698. 57. Loughlin, E. H., and Mullin, W. G.: Combined antibiotic therapy of tropical infections with PA-765 and PA-775, *Antibiotics Annual*

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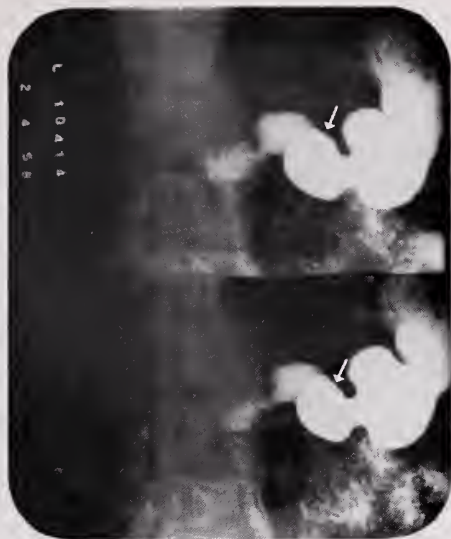
1956-57, New York, Medical Encyclopedia, Inc., 1957, p. 63. 58. McCloud, L. C.; Shidal, W., and Mulligan, J. L.: Clinical observations on infections treated with a combination of tetracycline and oleandomycin, to be published. 59. McFadden, H. W., and Schelhart, D.: Comparison of the *in vivo* sensitivity of micrococci to oleandomycin, tetracycline and a combination of oleandomycin and tetracycline, *Antibiotics Annual* 1957-1958, New York, Medical Encyclopedia, Inc., 1958, pp. 514-519. 60. Manara, G., and Gasparetto, A.: The first clinical experience with water-soluble Signemycin, *University of Padua, Minerva chirurgica* 13:535 (May 15) 1958. 61. Medina Morales, F.: The combination of tetracycline-oleandomycin (Signemycin) in the postoperative treatment of three cases of pulmonary resection, *Medicina, Mex.* 800:347, 1958. 62. Mehra, B. K.: Combating the resistant staphylococci, *Current Med. Pract.* 1:326-328 (May) 1957. 63. Mendiola, R.; Naranjo, R., and Briseno, F.: New contributions to the treatment of tuberculosis, *Medicina, Mex.* 37:269 (June 25) 1957. 64. Mendoza Diez, J.: Treatment of osteomyelitis with Signemycin, Thesis, Universidad Nacional Mayor de San Marcos, Facultad de Medicina, Lima, Peru, 1957. 65. Moggian, G.: Preliminary results of a new antibiotic association in obstetrics and gynecology, *Minerva med.* 48:2648 (Aug. 25) 1958. 66. Molinelli, E. A.; Vera Barros, E., and Ithurralde, D.: Tetracycline-oleandomycin in human brucellosis therapy, *Antibiotics Annual* 1957-58, New York, Medical Encyclopedia, Inc., 1958, pp. 692-697. 67. Montilli, G., and Avellino, M.: Esperienze con una nuova associazione di antibiotici (tetraciclina ed oleandomicina) in terapia dermatologica, *Dermatologia* 9:3, 1958. 68. Morador, J. L., and Morador, S.: Cause, prevention and treatment of staphylococcal infection in hospitals, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 1958, to be published. 69. Morador, J. L., and Tate, L. S.: Treatment of 52 cases of infections caused by coagulase-positive staphylococci with a combination of oleandomycin and tetracycline, *Antibiotics Annual* 1957-58, New York, Medical Encyclopedia, Inc., 1958, pp. 702-707. 70. Morador, J. L., and Tate, L. S.: The treatment of anorectal infections with Signemycin, *An. Ateneo Clin. Quirur.* 1:52 (Jan.) 1958. 71. Morel, A. S.: Surgical infections: a guide to therapy, *Clinical Review & Research Notes* 1:18-21 (July) 1958. 72. Morey, G. S.: Infections in nursing babies due to *Pseudomonas aeruginosa* (*B. pyocyaneus*) alone or associated with other organisms, *Rev. Hosp. nino*, 72:3, 1958. 73. Oates, J. K.: Trial of Signemycin in non-specific urethritis, *Brit. J. Vener. Dis.* 34:38, 1958. 74. O'Herlihy, F. C.: A clinical trial with Signemycin, *Medical Press* (London), p. 897 (Sept. 17) 1958. 75. Olmer, J., and Casanova, P.: Therapeutic notes: Clinical trials of Signemycin in the treatment of 59 patients, *Semaine hop. Paris*, Vol. 34, no. 2 (Feb.) 1958. 76. Otolenghi, C. E.; Frigerio, E. R., and Soto Jimenez, D.: Combined antibiotic therapy in 35 cases of osteomyelitis, *Bol. y trab. Soc. cir. Buenos Aires*, 41:739, 1957. 77. Pagola, J. G.; Benavides, L., and Heredia, A.: An evaluation of tetracycline-oleandomycin in the treatment of epidemic typhus, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 1958, to be published. 78. Pavone, M.; Anello, A., and Macaluso, M. P.: Signemycin in the therapy of infections of urinary passages, to be published. 79. Perez Villasante, G.: Postoperative treatment of the ear cavity, *An. Soc. Mexico de Otorinolaringologia*, No. 34-35:175 (May-Aug.) 1957. 80. Prokop, O.: On the question of staphylococcus infections resistant to therapy, *Der Praktische Arzt*, 12:145 (Feb. 15) 1958. 81. Quartil, M.: Efficacy of the association of oleandomycin and tetracycline in staphylococcal infections, *Aggiornamento Pediatrico*, 8:11, 1957. 82. Quirino, N.; Fukelman, R., and Achaval, M.: Treatment with oleandomycin-tetracycline of infections observed in clinical practice, *Dia med.* 30:2938 (Nov. 17) 1958. 83. Ragazzini, F.; Moggi, P., and Accella, M.: First clinical applications of Signemycin in pediatrics, *Minerva med.* 48:2667 (Aug. 25) 1957. 84. Randig, K.: Some experiences with Signemycin, *Deutsches med. J.* 8:447 (Aug. 15) 1957. 85. Rebelledo, L. M., and Hcredia, D. J.: Further clinical studies of an association of tetracycline and oleandomycin in the treatment of various infections, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 1958, to be published. 86. Rentchnick, P.: A combination of broad-spectrum antibiotics, *Medicine et Hygiene*, 379:562 (Nov. 30) 1957. 87. Revelli, E., and Durando, C.: Treatment of the nonspecific inflammatory component of tuberculosis of the female genital organs, *Minerva med.* 48:2658 (Aug. 25) 1957. 88. Rivera, J. A.; Brame, R. E., and Osborne, D.: Sensitivity of *Micrococcus pyogenes* from burned patients to the action of oleandomycin. The emergence of resistance to this antibiotic, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 1958, to be published. 89. Rondanelli, E. G.: The therapeutic problem of orchitis by parotitic virus, *Institute of General Clinical Medicine and Medical Therapy of the University of Pavia, Bulletin med. & surg. soc.*, Pavia, 71:1, 1957. 90. Saavedra Amaro, S., and Lopez Zepeda, L.: Comprobacion clinica de la Signemycin en el tratamiento de infecciones diversas, to be published in *Medicina, Mex.* 91. Sanchez Creus, P.: Los antibioticos de indicaciones limitadas, *Rev. clin. espan.* 69:378 (June 30) 1958. 92. Sangiuolo, F.: Therapeutic action of the tetracycline-oleandomycin (Signemycin) association, *Minerva med.* 48:2679 (Aug. 25) 1957. 93. Santos, A. A.; Ganora, H. M., and Brea, C. M.: Antibiotic prophylaxis in thoracic surgery, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 1958, to be published. 94. Schenone, H.: Genitourinary infections treated with the antibiotic combination tetracycline and oleandomycin, paper read at Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 1958, to be published. 95. Shubin, H.: Clinical evaluation of combined chemotherapy, oleandomycin and tetracycline, *Antibiotic M.* 4:174 (March) 1957. 96. Signer, A., and Vinci, G. G.: Signemycin in the healing of wounds, *Arch. Societa Med-Chirurg. Messina*, Vol. II, 1957. 97. Smazal, S. F., and Crowley, P. J.: Routine use of the antibiotics tetracycline and oleandomycin in combination for the treatment of infections represented in an unselected series of general office patients, to be published. 98. Steinman, E.: Trial of an antibiotic combination as a routine agent for treatment of infections in office practice, to be published. 99. Stritzler, C., and Frank, L.: Significance of the response of acne vulgaris to antibiotics, *Antibiotic M.* 5:109 (Feb.) 1958. 100. Talbot, J. R.: Experience with an antibiotic combination (tetracycline-oleandomycin) used routinely for anti-infective therapy in an office practice, *Wisconsin M. J.* 57:237-238 (June) 1958. 101. Tato, J. M.; Galli, L. A.; Rehniewski, C.; Arauz, S.; Games, J.; Bello, J.; de Sebastian, G., and Bergaglio, O.: Treatment of chronic sinusitis with a combination of oleandomycin and tetracycline, *Antibiotics Annual* 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 675. 102. Willcox, R. R.: Tetracycline and oleandomycin in combination in nongonococcal urethritis, *Antibiotics Annual* 1957-58, New York, Medical Encyclopedia, Inc., 1958, p. 672. 103. Willcox, R. R.: The treatment of nongonococcal urethritis with tetracycline and oleandomycin in combination (Signemycin), *Medical Press* (London) (Dec. 11) 1957. 104. Willemot, J. P., et al.: Signemycin in the treatment of pulmonary infections, *Bruxelles med.* 38:1026 (June 22) 1958. 105. Winton, S. S., and Chesrow, E. J.: A clinical study of combined chemotherapy, *Antibiotics Annual* 1956-57, New York, Medical Encyclopedia, Inc., 1957, p. 55. 106. Wittmoser, R.: Hospitalismus, *Chirurgische Praxis*, 3:281 (Sept.) 1957. 107. Zaldivar, C. G., and Falcone, F.: Preliminary results in osteomyelitis with tetracycline and the phosphate of oleandomycin (Signemycin), *Rev. Hosp. nino* 18:151 (June) 1957. 108. Zaldivar, C. G.: Complicated forms of chronic osteomyelitis, *Rev. Hosp. nino* 72:315 (Dec.) 1957.

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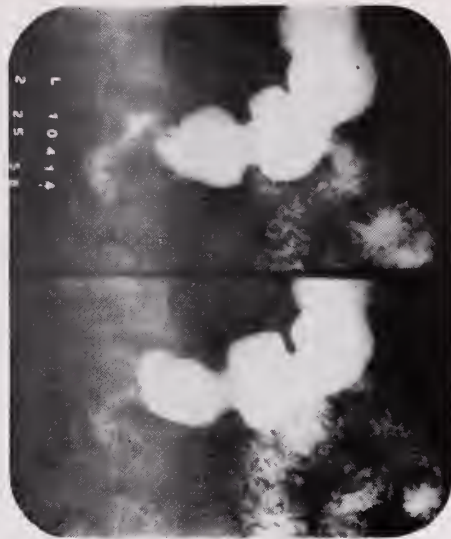




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References: 1. Shelmire, J.B., Jr.: Monographs on Therapy 3:164 (Nov.) 1958. • 2. Nix, T.E., Jr., and Derbes, V.J.: Monographs on Therapy 3:123 (Nov.) 1958. • 3. Robinson, R.C.V.: Bull. School of Med., U. Maryland 43:54 (July) 1958. • 4. Sternberg, T.H.: Newcomer, V.D., and Reisner, R.M.: Monographs on Therapy 3:115 (Nov.) 1958. • 5. Clark, R.F., and Hallett, J.J.: Monographs on Therapy, 3:153 (Nov.) 1958. • 6. Smith J.G., Jr., Zawisza, R.J., and Blank, H.: Monographs on Therapy, 3:111 (Nov.) 1958. • 7. Monographs on Therapy, 3:137 (Nov.) 1958. • 8. Howell, C.M., Jr.: North Carolina M.J. 19:449 (Oct.) 1958. • 9. Bereston, E.S.: South. M.J. 50:547 (April) 1957. And whatever the topical corticoid need, a suitable Squibb formulation is available—Kenalog-S Lotion—7½ cc. plastic squeeze bottles. Each cc. supplies 1.0 mg. (0.1%) triamcinolone acetonide, 2.5 mg. neomycin base and 0.25 mg. gramicidin. Kenalog Cream, 0.1%—5 Gm. and 15 Gm. tubes. Kenalog Lotion, 0.1%—15 cc. plastic squeeze bottles. Kenalog Ointment, 0.1%—5 Gm. and 15 Gm. tubes.



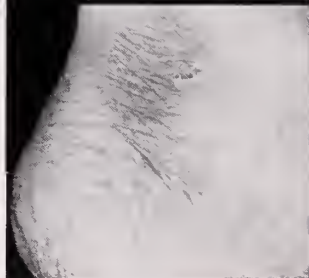
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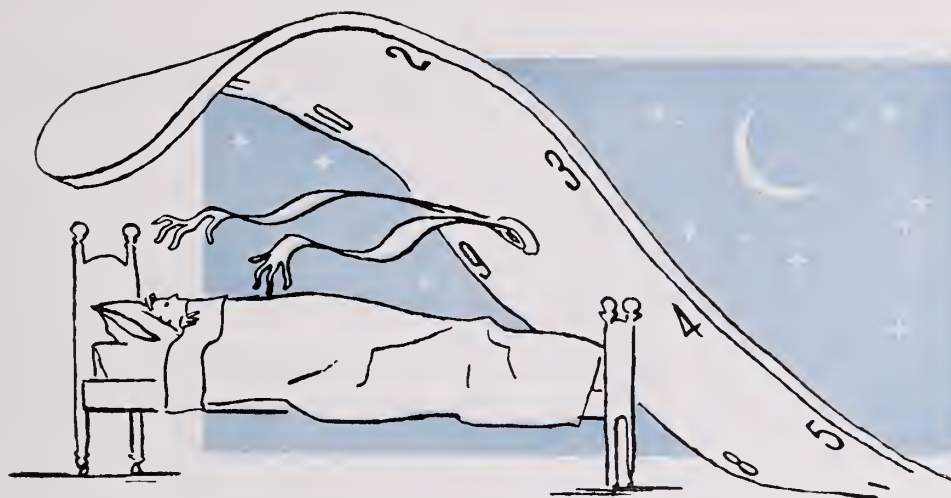
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\*Ethan Allen Brown, N.E. J. Med., 223:843.

F. K. Albrecht, Mod. Mgmt. Clin. Med., P674, Williams & Wilkins.

F. W. Wittich, J. Am. Ger. Soc., 3:239, 1955

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## THE WATCHES THAT WON'T RUN DOWN\*

### Results of Investigations of Victims of Radium Poisoning After an Interval of Thirty Years

SAMUEL D. CLARK, M.D.

The Author. Samuel D. Clark, M.D., of Cambridge, Massachusetts. Physician, Medical Department, and Medical Officer, Radioactivity Center, Massachusetts Institute of Technology.

IN 1933, a young National Research Fellow at University of California named Robley D. Evans published a paper in the *AMERICAN JOURNAL OF PUBLIC HEALTH* titled, *Radium Poisoning, a Review of the Present Knowledge*. This was twenty-six years ago. Only nine years before this publication, one of the first indications of the toxicity of radium was announced by a New York dentist, Doctor Theodore Blum, who published an article on osteomyelitis of the mandible and maxilla in the *JOURNAL OF THE AMERICAN DENTAL ASSOCIATION* in September, 1924. Evans' paper of 1933 was a scholarly, well-documented summary of the toxicity of radium as known at that time. The article described six physical laboratory tests for determining the presence of radium poisoning in living persons. Only two or three of these demanded the presence of the patient in the laboratory. Some of these tests were either originated by Evans or were developed by him in conjunction with other workers. The tests which are done today are in large measure a development of his early work.

In 1925, Doctor Harrison Martland, medical examiner of Newark, New Jersey, and his co-workers definitely pointed the finger of suspicion at radium in the cases of the luminous dial painters in New Jersey after several deaths had occurred there. It was the work of Martland and his contemporaries that brought about drastic changes in the radium industry with the result that within a few years most watch dial painters were very carefully supervised, and the practice of tipping the brush in the mouth was strictly forbidden. The publicity following the death of a few dial painters in the late twenties and early thirties created an erroneous

impression. Many assumed that all of the dial painters were dead, and the subject of radium poisoning was literally becoming a dead issue. For a small group of researchers, however, the subject was very much alive.

Those who had done any appreciable investigation of the matter knew that most of the radium remaining in the body after the first year probably remained there indefinitely. While an overwhelming dose was known to have a disastrous effect on the hematopoietic system, causing death in a period of one to five years, not much was known of the late effects of small amounts of radioactive deposits present over a period of many years.

It might be well to review briefly how radium and other radioactive substances produce their harmful effects. When radium is taken into the system (the route makes little difference), 70 to 95 per cent of it is excreted in the first few days to weeks. A small percentage remains because it has been stored in the inorganic bone structure, and once so stored it remains there indefinitely. The amount may not be very great, but it does not take much to produce a harmful effect. Radium, during its process of disintegration, gives off both alpha rays which can be likened to energetic atomic bullets with a range of about 50 microns, and beta rays. Many of the living cells in the path of these atomic bullets are killed, and a few are possibly altered in such a way that mutations in the form of cancer may develop. It should be mentioned that the disintegration of radium also produces penetrating gamma radiation which is utilized in the external therapeutic use of radium or radon seeds. This external effect, however, can be measured and utilized in specific amounts for specific purposes, and is similar in its use to a two million volt X-ray machine. The effects are cumulative only to the same degree that X-radiation is cumulative.

The techniques for the detection of radioactive substances in the human body have been known for many years. These techniques have been so refined that in a low background room such as the one at M.I.T. and several other laboratories it is possible to detect extremely minute traces with a high degree

\*From the Radioactivity Center, Department of Physics, and the Department of Medicine, Massachusetts Institute of Technology.

Presented at the meeting of the Providence Medical Association, at Providence, Rhode Island, February 2, 1959.

continued on next page

of accuracy.

For a brief period in the mid-twenties, parenteral radium compounds had been listed in new and non-official remedies as useful therapeutic agents. Many doctors injected hundreds of patients with radium solutions containing as high as 100 micrograms per dose. Many of the patients so treated were suffering from cancer, leukemia, or other fatal diseases so that one can assume little harm was done in these instances. Other physicians were prescribing oral medications, such as Radithor which contained about one microgram of radium and one microgram of mesothorium in each daily dose. (Mesothorium is an isotope of radium which differs from radium in that its half-period is  $6\frac{1}{2}$  years rather than 1600 years. For this discussion we may assume that, for equal disintegration rates, the toxic effects of the two isotopes are about the same in respect to the damage caused.)

The death of a prominent millionaire in Pittsburgh, in 1933, caused so much publicity that the use of oral radium compounds promptly ceased. In 1933, most of the known ill-effects of radium were painfully, violently, and dramatically fatal; and they occurred within a comparatively few years.

It is estimated that perhaps some two thousand persons absorbed detectable amounts of radioactive substances while engaged in the luminous dial painting industry. While probably several hundred individuals are still alive who either drank radium compounds or had parenteral injections of radioactive substances, probably not more than a handful of individuals, so far as we know, are in any danger from radium poisoning at the present time. Why then is this study worthy of anything more than academic interest? With the advent of nuclear weapons and nuclear power, our world has been subjected to a completely new set of substances which never existed before. Some of these are extremely hazardous. Many of them we believe, behave in a manner very similar to radium. Just how much of these substances we will accumulate in our systems is not a matter for discussion this evening. What many people would like to know, however, is what will be the effect of a given radioactive substance if it is stored in the human body for varying lengths of time and, more especially, over long periods of time. It seems to many workers that it is entirely feasible and proper to draw valid conclusions for these new substances from what we already know, or can learn in the future, from the effects of radium and similar substances. In order to look ahead and intelligently guess the effect of these new substances, we would do well to study carefully those individuals who, we have reason to believe, have harbored radioactive materials in their bones for the past thirty to forty years. It is therefore obvious that it is of the utmost importance to

track down and test every possible case of radium ingestion that we can, before they die of other diseases.

How is this being accomplished? The Atomic Energy Commission has recognized the importance of this research and for the past several years has aided this type of investigation in several places. The Argonne National Laboratory in Chicago has been working on this problem. The Radioactivity Center at M.I.T., under the direction of Professor Evans, has studied many aspects of this subject, and has been designated as another center for this type of research.

How does one go about finding new cases? Naturally, those who had heavy doses developed symptoms very early and sought medical aid or tried to get compensation. Those individuals who harbored only a small amount of radium in their systems were either completely unaware of this condition, or if it produced symptoms, it did so in an unrecognized fashion so that doctor and patient alike had no realization as to the true state of affairs. The first step, therefore, was to gain the confidence of the companies who had previously employed dial painters when they were putting paintbrushes in their mouths, so that we might find the names of the individuals who were involved, if the records still existed. With the attendant publicity surrounding the deaths of a few individuals in the late twenties, many of these companies went out of business; and their records were destroyed. A few companies, however, are still active and, fortunately for us, these include some of the larger firms. One such company, when first approached, was extremely chary of giving out any information at all. Having suffered from bad publicity twenty-five years ago, this was understandable. Grudgingly, they gave us the names of a few individuals who were drawing compensation from the company and therefore were well known in the community as radium cases. When it was seen that no bad publicity resulted from the testing of these individuals, the company began to consider our project more seriously; and we were given more names to investigate. Eventually, we had access to all of the employment records and had the complete and invaluable co-operation of the personnel department of this plant. We ended up with several hundred names.

The present technique for finding new cases is as follows:

When we have located a former dial painter, we ask her to recall, if she possibly can, the names of some of the individuals who worked with her. Many times she can remember one or two names, and frequently she remembers what happened to them or has some clue as to where they are living at the present time. In this way, one case may lead to



another. We also have the co-operation of the Department of Vital Statistics in the state capitol. Here we employ workers who check the marriage certificates of females from the town where the factory was located. Many cases have been ultimately traced in this fashion. Some of them have, over the years, moved many miles from the place where they painted dials thirty years ago. We are, of course, particularly interested in those who worked before 1927, when the practice of tipping the brush in the mouth came to a halt. Having spotted individuals and found out where they live, the next problem is to get them to come to M.I.T. for testing. Our procedure is as follows. We put in a telephone call and ask them whether or not they worked at the *X Company* painting dials. Many of them have completely forgotten this fact, and only after we quote them chapter and verse from the company's employment records do they remember it. The gruesome stories of the deaths of a few dial painters caused a certain amount of unconscious suppression of this episode in their lives. Our next step is to assure them that we do not expect to find anything wrong in their particular case. We explain that we wish to determine how many physically healthy people there are who were in contact with radium many years ago. We then ask if they will allow us to come out and interview them a day or so later. At that time, we pay a visit to the patient's home and explain the project in greater detail. We urge them to get in touch with some of the people who have already visited the Radioactivity Center. In many instances, the people who have already come to M.I.T. are our greatest boosters. Fortunately, most of the former dial painters will come without too much urging.

They arrive at a Cambridge hotel the night before the testing. On the morning of the first day, they are tested by the physicists, by two different types of procedure. The first consists of testing for radon and thoron in the expired air. This is accomplished by having them breathe aged air from a tank through a tightly fitting mask into a special flask. The other tests are done inside our low background enclosure, a small room, the walls of which are made of six-inch thick steel lined with a  $\frac{1}{8}$ " thickness of lead. Here we determine the total body burden of gamma-emitting isotopes by means of a very sensitive scintillation counter system. This method will detect as little as a few thousandths of a millionth of a gram of Ra in the entire body.

After spending a half, or sometimes a whole day, with the physicists, the subjects come over to the Medical Department where they are given a complete physical examination. X rays are taken of selected bones, blood samples are drawn, and the urine is tested. The patients then return home, and when the data are collected, a final report is sent to

the patient's family physician who, in turn, will relay the information as he sees fit. In most cases, the amount of radioactive substance present is minute, often of the order of two or three hundredths of a microgram. The physical, X-ray, and laboratory findings are usually negative. When incidental findings of interest are discovered in the course of the physical examination, these are passed on to the patient's family physician. These essentially negative cases, while not so interesting to the investigator, are none the less, vitally important to us for controls. Occasionally, we run across individuals who may have as much as one-half to one microgram in their systems. In cases having less than one microgram, some sort of difficulty referable to radium poisoning may sometimes be seen. Above one microgram, these difficulties occur almost invariably. One of the most common is a history of spontaneous fracture of one of the long bones or, strangely enough, the patella. Osteogenic sarcomas occur at about twenty times the expected frequency for persons of this age group.

The laboratory work rarely shows any abnormalities in the blood. The X-ray picture may show characteristic areas of rarefaction in the long bones near the metaphyses and a peculiar mottled effect in the skull. There may be surprisingly marked X-ray changes without any symptoms whatsoever.

There is one group in which we are particularly interested. These people, following a dormant period of twenty-five or more years after the initial deposition of the radium, develop a syndrome of deafness, visual disturbances, severe pains around the face and back of the eyes. There are practically no localizing signs either neurologically or by X ray, yet when they come to autopsy we find extensive neoplastic infiltration around the pituitary, often extending along the optic and the trigeminal nerves. Microscopic examination almost invariably shows a carcinoma arising from the lining membrane of the paranasal sinuses. All of these patients show body burdens of the order of 1-10 micrograms.

Our main objective is to discover with as much accuracy as is possible, what is the maximum permissible level of radioactive substances within the human body compatible with health for the individual and his or her descendants. Only by examining and testing many more individuals will we be able to state definitely what this level should be. We ask your co-operation in helping us to find our laboratory case material before it vanishes forever.

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This work is supported in part by the Division of Biology and Medicine, U.S. Atomic Energy Commission.

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## THE HISTOPATHOLOGICAL CHANGES INDUCED BY THE NITROGEN MUSTARDS IN THE LYMPHOMAS

### A Brief Review of the Literature

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WITH THE ADVANCES of the last quarter of a century in cancer chemotherapy, it was conjectured that eventually such antineoplastic agents might take their place with surgery and radiation as part of our armamentarium against this dread disease. In no other field has chemotherapy been as fruitful as in the treatment of the malignant lymphomas and leukemias.

Indeed, in so far as Hodgkin's disease is concerned, Gilbert,<sup>1</sup> in 1939, urged systemic roentgen therapy as the treatment of choice, whenever the absence of specific etiological factors was demonstrated, because no chemotherapeutic agent had yet proved its worth. Literally hundreds of compounds were tried, many of which were given for purely symptomatic relief.

This was the situation before any satisfactory compound had been discovered. When the mustards came into clinical use during 1942 and were found to be effective against some of the human lymphogranulomatoses, it was thought that they might be not only palliative themselves, but when combined with irradiation, potentially curative. The first part of this statement is true; for Jacobson *et al*<sup>2</sup> noted significant remissions in patients who were radiation-insensitive and suffering from severe lymphadenopathy. The second part of the statement is far from the truth, for Goodman *et al*<sup>3</sup> demonstrated that the mustards are not curative, remissions lasting only weeks or months, while some patients fail to improve at all. These authors described three cases, formerly resistant to radiotherapy, which were restored to sensitivity after courses of the nitrogen mustards.

Despite the dramatic clinical relief initially achieved by these agents, it was soon demonstrated that such remissions became progressively shorter; some cases had a rapid and fulminating recurrence of symptoms and lymphadenopathy. The literature on this aspect of the disease has been reviewed by Hoster, Dratman, Craver, and Rolnick.<sup>4</sup> Needless to say, these drugs are not the ultimate answer to our treatment of the malignant lymphomas.

#### *The Histopathological Mechanisms*

To understand the histopathological changes induced by these compounds, it is essential to discuss briefly the pharmacological activity of the mustards, especially in relation to their mode of action as mitotic poisons. This will further an understanding of the way these agents exert their specific changes upon normal and neoplastic tissues.

Berenblum and Schoental<sup>5</sup> conjectured that intranuclear precipitation of nucleoprotein, with genetic mutation and enzymatic destruction of the flavoproteins systems, would interfere with the function of the mitochondria, the chromosomes, and the microsomes; but it was mainly through the work of Auerbach, Robson, and Carr<sup>6</sup> that the action of the mustards upon gene mutation and chromosome rearrangements was elucidated. Working with *Drosophila melanogaster*, the common fruitfly, these writers noted that the genes affected did not always mutate immediately, but tended to remain quiescent until future cell divisions. Apparently, these hereditary changes are irreversible, because the mutations persist even after the mutagen itself has been destroyed, so that subsequent mitoses leave the daughter cells deficient in chromosomal makeup. Cells so constituted must either perish or show a reduced viability.

Loveless and Revell<sup>7</sup> emphasized that the chromosomes broke up at the areas on the genes containing hetero-chromatin, which have a high nucleic charge in the resting nucleus. Since the mustards have an affinity for such acid groups, it was suspected that the agents combined with the desoxyribose nucleic acid components during the resting stage and caused breaks in these segments.

Bastrup-Madsen,<sup>8</sup> working with fibroblast cultures attributed the interference to gene mutations, chromosomal aberrations, and disturbances in polarization. The affected cells showed chromosomal aberrations, adhesive cellular components, and bridge formation at telophase, which resulted in disintegration during division, and the production of less viable cells. The production of such lethal genes undoubtedly is related to the antineoplastic changes seen in the daughter cells.

A significant contribution to the literature of the biological action of the mustards was made by Gilman and Philips,<sup>9</sup> whose investigations were

carried out at the Sloan-Kettering Institute for Cancer Research in New York.

These authors described the cytotoxic and nucleotoxic effects of these compounds, the susceptibility of the cells being related to their proliferation and division, thus suggesting that mitotic inhibition might not of itself imply a primary action on the nucleus, since mitotic cessation is seen in the resting phases between mitoses. Evidence is offered that a nucleotoxic mechanism is present, for in specific dosages the mustards act upon the chromosomal structures without influencing other cellular components. This produced inheritable abnormalities "which can be reproduced indefinitely by normal processes of cell division" and thereby be transmitted from generation to generation. The exact mode of action, whether by direct combination with important cellular components, or by induced structural abnormalities in disrupting enzymatic systems, is still open to debate.

In another article Philips<sup>10</sup> summarizes various views on the probable mechanisms of action. It has been mentioned that the nucleoproteins and nucleic acids react with the mustards. Is it not then logical to assume that the dividing particles containing these ingredients are particularly sensitive, since these nucleic acids are an inherent component of the genes?

#### *The Mustards in Hodgkin's Disease*

It is necessary to discuss the origin of a specific cell-type, i.e., the Reed-Sternberg cell in Hodgkin's disease, to illustrate more clearly the life cycle of a lymphomatous cell in its response to chemotherapeutic agents.

Ackerman, Knouff, and Hoster<sup>11</sup> demonstrated that this cell arises from the reticulum cell, since cytochemical and pathological examination of biopsied specimens of lymph nodes revealed "transitional forms between normal and elongated reticulum cells forming the stroma and sinuses of the lymph node and large definitive Hodgkin's cells and their early and late forms."

The morphology of the Hodgkin's cell was divided into six types, depending upon the stage in its life cycle:

- "(1) enlargement of the elongated reticulum cell forming the stroma and sinuses;
- "(2) rounding of the reticulum cell;
- "(3) continued enlargement of the reticulum cell resulting in a cell containing a large nucleus with sparse chromatin which frequently aggregates about the nuclear membrane and nucleoli;
- "(4) indentation and lobulation of the nucleus of the large (Hodgkin's) mononuclear cell and a concomitant enlargement of the cytocentrum; multinucleated cells may develop

during this stage;

- "(5) thickening of the chromatin, first at the nuclear membrane, and nuclear borders and later throughout the nucleus, wrinkling of the nucleus, and fragmentation of the nucleoli;

- "(6) karyorrhexis."

These authors commented upon the fact that the deoxyribosenucleic acid content of many of the definitive Reed-Sternberg cells is greater than that of a normal reticulum cell. Here one may postulate that since the mustard compounds exert a profound effect upon the nuclei which contain a high content of nucleoprotein, the cells of the lymphomas might be particularly susceptible to these compounds. Certainly, this is true of Hodgkin's disease.

Human tissue studies of Reed-Sternberg cells have been made by Lewis<sup>12</sup> and Hoster and Reiman.<sup>13</sup> Miss Lewis took motion pictures of these cells which indicate that the Hodgkin's cell arises from myeloid elements, rather than from lymphoid or monocytic precursors. It seems logical to suppose that experiments, whereby these human tissue cultures are exposed to the nitrogen mustards, will be eventually carried out. Such evidence would be invaluable in deciphering the various histopathological effects of the drugs, thereby affording a clearer picture of their possible mode of action in these cell-types.

Spitz,<sup>14</sup> at the Memorial Hospital in New York, examined post-mortem material from patients treated with the nitrogen mustards and observed that specific cytological changes were induced in the Reed-Sternberg cells. He noted marked ballooning and enlargement due to fat globules. Swelling occurred in the nucleus, with a disruption of chromatin structure and occasional pyknosis. These effects were noted seven days after treatment; but not all of the tumor cells were so affected, since occasional mitoses were observed. Random sections of lymph nodes, stained for fat, also demonstrated this "blistering" effect.

"Sudanophilic droplets were noted in the phagocytes and the reticulum cells of hyperplastic nodes, in the neoplastic cells of Hodgkin's disease, both untreated and following roentgen therapy. Except in rare instances, the accumulation of this lipid material following nitrogen mustard therapy—was far greater than under any of the conditions mentioned before."

Eight days later, the histological picture had changed. Most sections then revealed a transformation of the tumor components into a more pleomorphic condition, with multinucleate giant cells predominating. The tumor appeared more like a reticulum-cell sarcoma than like Hodgkin's disease. It was noted that though there was a decrease

*continued on next page*



in the number of tumor cells, those that remained unaltered continued to proliferate, as shown by increased mitotic figures in the remaining viable cancer cells.

In a series of Hodgkin's granulomas reported by Doctor Spitz, she observed marked alterations in these cells following therapy. While lacking detailed material, it was noted that it was almost impossible to identify any of the cell-types except eosinophiles in an aspirated lymph node.

"The remainder of the cells were enlarged, due to ballooned, vacuolated cytoplasm and often swollen nuclei, in which the details of chromatin structure could seldom be seen. It was not possible to determine whether these cells represented altered, non-neoplastic reticulum cells or those of the Reed-Sternberg type. Nevertheless, it was noted that the latter, prominent in the pretreatment node, could not be identified in the tissue only four days following therapy. Mitoses were not numerous; lymphocytes were reduced in number."

In a second case, a seven-day therapy surgical specimen showed scarcely any changes in the numbers of eosinophiles, or lymphocytes, but ballooning of cells, with abnormal chromatin structures was observed. Two months later pleomorphic changes were very noticeable.

In the remaining cases the histological picture was variable. Some showed areas of necrosis and fibrosis, while Reed-Sternberg cells were especially conspicuous in post-mortem material.

For an evaluation of the histopathological response to nitrogen mustards, in patients with Hodgkin's disease, only biopsy material from lymph nodes, spleen, and a few other viscera were available to the pathologists. This was in marked contrast to the information obtained from animal studies, where autopsies could be performed at will.

Damashek, Weisfuse, and Stein<sup>16</sup> performed serial bone marrow studies on eleven cases of Hodgkin's disease after therapy with the nitrogen mustards. They noted decrease in the size accompanying cellular hypoplasia after twenty-four hours.

"Polymorphonuclear neutrophils showed hypersegmentation. Erythropoiesis was suppressed. Within two to four days there was a reduction in the number of myelocytic cells and a relative increase in the number of more mature forms. Bizarre, distorted myelocytes, metamyelocytes, polymorphonuclear neutrophils, and megakaryocytes were noted with moderate frequency. Marked hypoplasia of the bone marrow followed nitrogen mustard therapy in seven cases. . . . Suppression of granulopoiesis was noted within two to four days. The fall in the peripheral leucocytes occurred shortly thereafter, reaching a maximal leukopenia on the twenty-fifth day. This prompt reflection of

an effect upon bone marrow is undoubtedly due to the short survival time of the leukocytes in the peripheral blood."

Spurr<sup>17</sup> and his co-workers studied the bone marrow of Hodgkin's patients, based upon serial sternal aspirations and rib biopsies, before and after treatment. Their investigation revealed a profound increase of metamyelocytes, but a proportional decrease in all immature myelocytes. Erythropoiesis was depressed. The majority of cells stained poorly, having dark nuclei and poor cellular detail. In contrast to the other publications, a quick degeneration of cells occurred, with only reticulum cells, plasma cells, and megakaryocytes remaining. Immense destruction took place in one case which left only scattered blast precursors, plasma cells, reticulum cells, and fatty debris.

Jacobson *et al.*,<sup>18</sup> experimenting with rabbits, suggested that the induction of a hyperplastic marrow before treatment with the nitrogen mustards might be used to protect normal hematopoiesis in bone marrow when such agents are prescribed for therapy in the malignant lymphomas. These authors stated that a proliferating marrow affords protection from the lethal effects of the nitrogen mustards by mobilizing the hemocytoblasts and basophilic erythroblasts which are inherently less susceptible to these compounds than are their mature brothers. Transformation by heteroplastic regeneration from reticulum cells contributed to the rapid recovery.

In Hodgkin's patients of the Damashek series<sup>19</sup> serial lymph node biopsies were done in the six cases. The pathological picture was composed of lymphocytes, eosinophiles, polymorphonuclear neutrophils, plasma cells, reticulum cells, and Reed-Sternberg cells. Again, the twenty-four hour examination revealed the characteristic pattern of decreased cellularity and lymphocytic fragmentation. Four days later, this tendency toward degeneration was increased. Vacuolation and hypersegmentation were noted in the polymorphs, and the reticulum cells were pyknotic.

As regards liver pathology, miliary necrosis was observed in three patients, all of whom died. The hepatic cells were markedly necrotic, such karyolysis being attributed to the therapeutic measures employed. Bierman<sup>20</sup> and his group failed to substantiate such liver injury. Using heavy doses of the drug and employing pre- and post-treatment liver function tests, they could demonstrate no pathological effects. The patients were examined after several months and no change was noted. Prothrombin times were not remarkably altered during these researches.

#### *The Mustards in Other Lymphomata*

Landing's collaborators<sup>21</sup> have investigated the systemic pathological effects of some thirty-four



nitrogen mustards and related compounds. Using twenty-gram male mice, major pathological lesions were found in numerous organs. Renal and pulmonary injuries were commonly seen. Three compounds in the series produced central nervous system damage. These authors emphasized that the former group of tissues actually "resemble tumors in their relatively rapid mitosis rate, and possibly also in more fundamental biochemical factors. . . . The bone marrow and the gastrointestinal mucosa, then, seem to be the tissues from which cytotoxic activity of the mustard type can best be gauged."

Briefly, in tissues and organ systems heretofore not considered, the lungs showed pyknosis of cells in the alveoli, the kidneys, proximal tubular degeneration with sloughing epithelium, and the testes, pyknosis, inhibited mitoses, and disruption and sloughing of spermatogenic cells. The gastrointestinal tract pathology included nuclear fragmentation, while the brain revealed focal gliosis and occasional necrosis.

In the same article the authors furnish bone marrow evidence that compounds of high toxicity were less efficient in producing generalized visceral injury than were the mustards of lower toxicity. They suggested that a quantitative amount of drug (i.e., molecules per cell) was required for the production of a specific mustard effect, and that there is a level at which mustards are effective on proliferating cells.

Wintrobe *et al*<sup>22</sup> have summarized the pathological changes seen in the peripheral blood after treatment of twenty-eight patients with Hodgkin's disease suffering from lymphomata. Invariably there was a leukopenia, especially apparent in the lymphocytes and granulocytes. A slight decrease in erythrocytes eventually reversed itself, and the anemia which had been present disappeared. The leukopenia also became less severe.<sup>23</sup>

An interesting publication by Masouredis *et al*<sup>24</sup> has contributed much to our knowledge of the mechanism of action of the mustards in the lymphomas, from the histopathological viewpoint. Using tracer doses of radioactive phosphorus (300 microcuries), they studied the distribution of mustards in the blood, urine, and tumor tissue, before and after treatment. In half of the patients responding well to such treatment, it was determined that both tumor and non-tumor tissue took up  $P^{32}$  slowly after nitrogen therapy, that excretion in the urine was greatly increased, and that the blood level remained unchanged. Those patients not responding to therapy had no alteration in the uptake curves, before or after treatment.

In Doctor Spitz's<sup>25</sup> series the Malpighian follicles in the spleen were profoundly affected. Three cases showed no follicles whatsoever, while in

others there was necrosis of lymphocytes, fibrinous debris, and barren sinusoids with scattered macrophages. The red pulp appeared necrotic in most places.

The glomerular apparatus in the kidneys of five patients was enlarged, with swollen endothelial cells and thickened basement membranes. No specific alterations of liver or adrenal histology were observed, and when present, were not attributed to the mustard therapy.

Intensive study of gastrointestinal sections showed "no unusual alterations" in any part of the tract as far as the mucosal epithelium was concerned. Occasionally, lymphoid follicles in the ileum and colon were atrophic, and purpura was present throughout the system.

Besides these important effects, the author reported that in the testes of many males, 90% revealed some degree of testicular atrophy. This emphasized the marked injury to testicular spermatogenesis. There was shrinkage of the tubules, thickening of the basement membrane, and a variable absence of spermatocytes and spermatids. Sertoli cells alone remained viable in most of the seminiferous tubules. It appeared certain that the mustards exerted a profound depressant effect upon the germinal epithelium, since in none of the sections were there more than a few completely hyalinized tubules.

There are many questions about the histopathology of tissues treated with nitrogen mustards which remain unanswered. Patients with Hodgkin's disease commonly experience various gastrointestinal symptoms which are directly attributable to the mustards. Goodman *et al*<sup>30</sup> observed frequent nausea and emesis, with transient anorexia after injection. Diarrhea is less commonly observed.<sup>31</sup>

In dogs, extensive intestinal injury with hemorrhages and ulcers was seen.<sup>32</sup> Despite this evidence in experimental animals, Spitz<sup>33</sup> could not demonstrate any damage to the gastrointestinal mucosa in patients treated with the mustards.<sup>34</sup>

Sugiura and Stock,<sup>35</sup> working with collaborators,<sup>36</sup> tested these cancer chemotherapeutic agents against a spectrum of tumors. Their results showed the inhibitory and destructive action of the nitrogen mustards. The differences in effectiveness against the various tumors demonstrated the value of such tumor spectrum studies. However, it is not enough to observe the pathology of animal tissues only, for more work upon human material is needed.

#### *Similarities to Roentgen Rays*

One cannot study the lymphomas without noticing the similarity between the effects of the mustards and roentgen rays. These agents are therefore justly called "radiomimetic"<sup>37</sup> compounds. As the fundamental mode of action of X rays may be simi-

## ALCOHOL AND TUBERCULOSIS

## A Study of 200 Patients Admitted to the

Dr. U. E. Zambarano Memorial Hospital, Wallum Lake, Rhode Island

WILLIAM B. O'BRIEN, M.D., WILLIAM V. VINDZBERG, M.D., AND GLADYS LONGO

The Authors. William B. O'Brien, M.D., Superintendent; William V. Vindzberg, M.D., Senior Physician, and Miss Gladys Longo, Medical Social Worker, all of the Dr. U. E. Zambarano Memorial Hospital, Wallum Lake, Rhode Island.

THIS PAPER presents a study of 200 patients over forty years of age, who were admitted to this hospital between August, 1954, and September, 1955. Duration of the disease and the results of treatment were followed to July, 1958.

Of these 200 patients, 15 were non-pulmonary; tuberculous patients, therefore, numbered 185.

This paper is based on the marital status and the quantity of alcohol consumed. The amount of alcoholic consumption is designated as follows: 3+ = Heavy; 2+ = Moderate; 1+ = Occasional; 0+ = None.

Alcoholic consumption among these 200 patients is as follows: 70, 3+; 29, 2+; 34, 1+; 63, 0+; 4, ?

*Ages of patients:* 40 to 50 year—60; 50 to 60 year—62; 60 to 70 year—51; 70 and over, 27.

*Male—Married and Unmarried* (single, separated, divorced, widowers): Married, 76; and Unmarried 76.

Of the married males, 58 were successes, medically or surgically—18 were failures either medically or surgically.

Of the unmarried group 57 were successes medically or surgically and 19 were failures.

*Married Group:* 1 admission, 55; More than one (2 to 6) 21—27.63%.

*Unmarried Group:* 1 admission, 33; More than one (2 to 7) 43—56.58%.

*Failures:* 37 Male.

*Alcoholic Consumption*

3+	2+	1+	0+	?
13	5	5	11	3

*Female—Married and Unmarried* (single, separated, divorced and widows): Married, 11; Unmarried, 20; Non-pulmonary, 3; Left against advice in a very short time, 2.

Of the married females, 7 were successes, medically or surgically, and 4 were failures.

Of the unmarried group, 16 were successes, medically or surgically, and 4 were failures.

*Married Group:* 1 admission, 8; More than one (2), 3.

*Unmarried Group:* 1 admission, 15; More than one (2 to 4), 5.

*Failures:* 8.

*Alcoholic Consumption*

3+	2+	1+	0+	?
2	1	0	5	0

*Deaths:*

Up to July, 1958—36

Of this total 28 were male and 8 were female. Eleven deaths were in the nontuberculous group pointing up the trend of admitting increasing numbers of this type of case at our hospital and also the death of patients with inactive tuberculosis from cancer and other fatal conditions. (See Table)

*Follow-up Study*

Male 164 (12 nontuberculous)

Female 36

Studies on these patients can be found in the subsequent tables.

## SUMMARY

This study of 200 patients, between August 1954 and September 1955, shows that successes and failures were about equal in as far as marital status is concerned, but the duration of the disease and the number of admissions varies. The reason for this is the unco-operativeness of patients in the unmarried groups.

The reason for the difference in failures between 0+ group and 3+ group is the age.

In the 0+ group there were 9 patients between 60 and 86. In the 3+ group there were 6 patients between 60 and 70 who were failures. There was no patient over 70 in the 3+ group.

Most of the patients who were failures in all groups had more than one admission. From this study it appears that the quantity of alcohol consumed does not have much effect on the treatment of tuberculosis; but alcohol consumers do suffer

from malnutrition, poor general health, bad hygiene, disability, and are very prone to readmission.

The only important effect is this, that alcohol does interfere with the normal course of treatment of the patient; and furthermore such a patient becomes a real health menace when he is turned loose into the community.

In this study females proved in every way far more co-operative than males.

We wish to thank Dr. Norman J. Wilson, associate of the Overholt Thoracic Clinic, for suggesting this survey.

We are grateful to the Social Service Department for their co-operation in consulting with relatives, friends and other sources to determine the amount of alcohol consumed by the patients.

We thank the Medical Office for their co-operation.

## ALCOHOL AND TUBERCULOSIS

200 Patients

## Marital Status

Married	Single	Separated	Divorced	Widowed
96	47	13	10	34

MALE 164

82	42	11	8	21
----	----	----	---	----

FEMALE 36

14	5	2	2	13
----	---	---	---	----

## Age

	40-50	50-60	60-70	70 and over
Male	60	62	51	27
Female	46	53	43	22
	14	9	8	5

## Diagnosis

	Far	Moderately	Minimal	Inactive	Non-Pulm. Tbc.
M.	106	62	15	2	15
F.	90	51	10	1	12
	16	11	5	1	3

## Quantity of Alcohol Consumed

	3+	2+	1+	0+	?
M.	70	29	34	63	4
F.	65	28	24	44	3
	5	1	10	19	1

## Duration of Disease to July, 1958

Year	0-1	1-2	2-5	5-10	10-30	Other than Pulm. Tbc.
M.	33	61	37	22	30	17
F.	20	54	33	20	25	12
	13	7	4	2	5	3
						+2 (poor gen'l condition)

## Sputum

	Positive	Negative	Miscellaneous
M.	142	57	1
F.	122	41	1 (left A.A. next day)
	20	16	

## Result up to July, 1958

	Success		Failure		Non-Pulm.	?
	Med.	Surg.	Med.	Surg.		
M.	91	47	33	12	15	2
F.	77	38	27	10	12	
	14	9	6	2	3	2

(Left A.A. in short time)

## Result

Marital Status			Number of Admissions							
			MALE							
	Success	Failure	1	2	3	4	5	6	7	
Married	58	18	55	17	3				1	
			Total 21-27.63%							
Other than married	57	19	33	21	13	4	3	1	1	
			Total 43-56.58%							

## Age and Number of Admissions in 0+ Group of Failures - Males 11

Age	55	60	67	61	69	80	70	65	54	86	76
Number	2*	4*	1	1*	1*	2	3*	6*	2*	3	1

## Age and Number of Admissions in 3+ Group of Failures - Males 13

Age	69	66	57	62	48	66	58	50	53	46	44	66	64
Number	4*	2*	2*	3*	1	2	2*	3*	2*	2*	1*	2*	1

\*Left against advice

## Deaths Up to July, 1958 (36)

Male—28				Female—8			
Tbc.	Non-Tbc.	Tbc.	Non-Tbc.	Tbc.	Non-Tbc.	Tbc.	Non-Tbc.
21	7	25	11	4	4		
ALCOHOL				NUMBER OF ADMISSIONS			
Male	Female						
8 — 3+	2 — 1+	1	2	3	4	5	6
3 — 2+	6 — 0+	19	8	5	2	1	1
5 — 1+							
12 — 0+							

concluded on next page



	FEMALE		1	2	3	4	5	6	7
	Success	Failure							
Married	7	4	8	3					
Unmarried	16	4	15	4		1			

3 Non-pulmonary tuberculosis.  
2 Left against advice in short time.

**Failures and Alcohol (37) Male  
Up to July, 1958 (8) Female**

	3+	2+	1+	0+	?
M.	13	5	5	11	3
F.	2	1		5	

**Marital Status in Deaths**

	Married	Single	Separated	Divorced	Widowed
	15	7	2	2	10
Male	11	7	2	1	7
Female	4			1	3

**Non-Pulmonary Tuberculosis**

**MALE**

- 1 Pulmonary fibrosis
- 1 Tuberculous meningitis
- 3 Carcinoma of the lung
- 1 Retroperitoneal tuberculosis
- 1 Spinal tuberculosis
- 1 Pulmonary pathology
- 1 Bronchiectasis
- 1 Silicosis
- 2 Deferred

**FEMALE**

- 1 Genitourinary tuberculosis
- 1 Cervical adenitis
- 1 Right tuberculous inguinal and axillary abscesses

**HISTOPATHOLOGICAL CHANGES INDUCED BY  
THE NITROGEN MUSTARDS IN THE LYMPHOMAS**

*concluded from page 245*

lar to that of the nitrogen mustards, and Giese<sup>38</sup> would have us believe so, there is no doubt that the histopathological lesions produced by both are quite alike.<sup>39</sup> Brues *et al*<sup>40</sup> emphasized that, as with roentgen therapy, there is a wide diversity of response to treatment. Remissions after radiation, though shorter in duration, are similar to those seen with the nitrogen mustards. Indeed, resistance or insensitivity to each inevitably develops during the course of the treatment.

Craver<sup>41</sup> pointed out that since 1942 the mustards have found their greatest use in the lymphomas, but he emphasized that in these conditions any tissue or organ may become infiltrated. Deep lesions may affect bone, and here the mustards have not proved satisfactory. In another article, the same author<sup>42</sup> gives us no hope that these chemotherapeutic agents are able to cure the malignant lymphomas.

Gellhorn and Collins<sup>45</sup> made a critical evaluation of the treatment now available for these diseases. In the Hodgkin's series, two groups of patients were

studied: 67 cases received alternately, radiotherapy and nitrogen mustard; 65 cases received only ionizing radiation. The authors emphasized that while the chemotherapeutic agents did not alter the duration of the disease or life expectancy, they are an important adjunct to radiotherapy. Evidence was presented that they reduced by one-half the amount of time required for irradiation.

**SUMMARY**

Diamond<sup>47</sup> in describing the four main levels at which chemical compounds exert their anti-neoplastic effects remarks that no substance yet available in the fight against the lymphomas causes necrosis of tumor cells alone. Most of them influence or disturb the "physiological systems" essential for cellular proliferation. For example, the nitrogen mustards act upon all cells, but especially upon the bone marrow, reticuloendothelial, and lymphatic tissues; this is the reason that the most important pathology lies in this group of highly proliferative tissues.

From a survey of the literature it appears improbable that advances in radiology will improve the treatment of the lymphomas,<sup>48</sup> but it seems likely that chemotherapy holds promise of providing more effective methods of management.<sup>49</sup>

We are in a new era; the evidence is accumulating that in the future, perhaps in the near future, we shall have new and better chemical agents to aid us in the crusade against carcinoma.<sup>50</sup>

A list of REFERENCES for this article is available upon request.

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## THE VALUE OF PHENYLBUTAZONE (BUTAZOLIDIN) IN GENERALIZED OSTEOARTHRITIS

JOSÉ M. RAMOS, M.D.

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The Author. *José M. Ramos, M.D., Senior Physician  
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ACUTE EXACERBATIONS of osteoarthritis in the middle-aged and the elderly have for decades been an extremely difficult and an almost insoluble problem for the general practitioner and internist.

These cases have always been looked upon with despair as the natural results of an aging process and whatever treatment was administered, aside from psychotherapy, was merely palliative; the doctor ran through an armamentarium of the various analgesics in order to find some drug that would allay the patient's aches and pains.

With the advent of the corticosteroids new hope arose among practicing physicians for here, they thought, was an antiphlogistic and antirheumatic capable of relieving the multiple pains of the aging osteoarthritic and that, in the future, the aging process would be, at last, comfortable.

Unfortunately, this did not prove to be so, for it was found that the corticosteroids exerted no palliative action on the osteoarthritic process and disappointment was again rampant.

Since the introduction of phenylbutazone in 1951, many practicing physicians have found that it is a fairly successful therapeutic agent in a variety of conditions affecting the musculo-skeletal system. Its analgesic, antiphlogistic and antirheumatic action merited consideration, and there is no doubt that many of the patients treated for these conditions were benefited.

At this time, however, a pall was cast over the enthusiasm of most physicians because of the many reports about the extremely toxic effects of the drug. Reports of fatalities due to agranulocytosis, aplastic anemia, thrombocytopenia, bleeding, gastric ulcers and hypersensitivity reactions began to appear in the literature. Accordingly, the pendulum swung to the opposite extreme of conservatism and the drug was looked upon, as it is at the present time in many areas of the country, with skepticism and whenever a dosage of 100 mgm. was administered it was felt that a complete blood count and hematocrit test should be done for the control of a possible blood dyscrasia.

In our study of 150 cases of generalized osteoarthritis with acute exacerbations, phenylbutazone was used with marked success in the majority of cases and the toxic reactions encountered were of a mild degree and easily controlled.

The dosage advised in the beginning was, undoubtedly, heavy and toxic. It was found that approximately one third of the oral dose was concentrated in the plasma; it was bound to the plasma protein, so that the protein-bound phenylbutazone acted as a depot, while the unbound portion was rapidly metabolized. It was also found that at doses of 800 mgm. daily the plasma level was only slightly higher than at doses of 400 mgm. daily. There is little to be gained in the administration of higher doses especially when the possibility of toxicity is increased.

In our study, a dosage of 300 mgm. daily was administered for five days, and then a dosage of 200 mgm. daily was continued for three days.

At the end of the eight days of treatment, therapy was discontinued for a period of not fewer than ten days and not more than two weeks. In no instance were toxic reactions noted throughout our study of the 150 patients. If acute exacerbations were noted after this waiting period of ten days to two weeks, the drug was readministered on the same schedule; otherwise it was suspended until such time as recurrences occurred. Complete blood counts and hematocrits were done once a month on these patients and no evidence of granulocytopenia was noted; nor were there any cases of gastrointestinal bleeding.

However, and here one should make distinctions as to the type of cases in which the drug would be contraindicated; it was never used in hypersensitive states such as asthma or allergic dermatitis; nor was it used in cases that were being treated for duodenal ulcer, or anemia of any kind.

In only one instance was it used in a patient with bronchial asthma, suffering from an acute exacerbation of an osteoarthritis of the spine. The administration of the drug had to be discontinued after two days of therapy, because of increasing bronchial spasms and an exaggeration of her asthmatic state.

In another patient with an active duodenal ulcer, therapy was discontinued after three days because the epigastric distress, burning and discomfort

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which she had not suffered from for many months, returned with marked severity.

Oedema of the ankles was noted in only 2% of our cases. This disappeared immediately after discontinuance of the drug for a week. In no instance was this drug used in elderly patients with congestive failure or obvious renal impairment, since it has a tendency to produce salt and water retention in spite of the fact that it has no hormonal action.

The gastrointestinal reactions were of a minor kind, consisting of flatulence, epigastric distress and sometimes a hint of nausea. These reactions sometimes disappeared when the drug was prescribed in the middle of the meal, or when two or three glasses of milk were taken with the drug.

Salivary gland swelling, hematuria, toxic psychosis, optic nerve atrophy and exfoliative derma-

titis, all of which have been cited as possible reactions to the drug, were not noted during our study.

We believe that after using phenylbutazone for the last eight years, since its introduction to our medical armamentarium, and after employing it in 150 cases of the acute exacerbations of osteoarthritis, not only of the spine, but of the other joints of the body, we can say that, to date, it is one of the most useful and important antirheumatic drugs. However, consideration should be given not only to its mode of administration, but also to the various conditions that constitute contraindications to its use. We are of the opinion that, by administering the drug in the manner prescribed above, untoward reactions can be obviated, and the patient markedly benefited.

No. of Pts.	Duration of Therapy	Response	Side Reactions					
			Rash	G. I. Upset	Granulocytopenia	Anemia	G. I. Bleeding	Fluid Retention
98	16 Days	Good	1.5%	1%	0	0	0	2%
50	32 Days	Good	.5%	0	0	0	0	0
2	64 Days	Fair	0	0	0	0	0	0

In the group of ninety-eight patients, about 4% had a good response after eight days of therapy, but relapsed quickly and required a further eight days of therapy to clear up the polyarthralgia or spondylitis.

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## TECHNICAL ASSISTANCE PROJECTS FOR MENTAL HEALTH

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FOR THE past four years there has been available a special grant-in-aid program known as Technical Assistance Projects, or T.A.P., for short. Their purpose is to extend the consultation and technical assistance now provided to states through mental health consultants by the development of projects designed to increase the scope and effectiveness of state mental health programs. Thus it is possible for State Mental Health Authorities to plan with the regional consultants of the United States Public Health Service for appropriate workshops on special mental health topics for selected groups.

The workshop-conference technique is an accepted method that has already found its place in a total program. The Technical Assistance Project follows the general pattern of a limited group (10 to 40 participants) meeting together for from one to five days to hear addresses by "experts" on selected subjects, followed by small workshops for group discussion. Under the terms of the project, proceedings of the workshop are published, thus making the basic information available to a wider audience.

Although there is room for considerable flexibility in the design of a conference, the T.A.P. described here used a combination of didactic address by group leaders, followed by an opportunity for exploration and discussion in small groups. For a workshop of short duration (two to three days), this is the most efficient procedure. In spite of current emphasis on group dynamics, a lecture is still a very efficient technique for transmitting facts and "expert" opinion in the shortest time to a large audience. All participants heard the principal address at the opening conference dinner as well as the three workshop themes the next morning. The small groups limited discussion to single themes. The workshop leader's remarks bring a definite body of knowledge to serve as a nucleus for group discussion. This degree of formalization expedites

group cohesion. Additionally, the address makes identical data available to nonparticipants who will read the proceedings. Besides the leader, each workshop had a second resource person to provide balance. In this T.A.P. the leaders were all educators, while the resource persons were drawn from the disciplines of psychiatry, psychology, and social work.

A workshop can, of course, be judged on its own merits. In doing so, however, one seldom evaluates the workshop in the context of a total program or as a mid-point in a continuum of related and parallel events. It was felt such a correlation with the events preceding and following such a conference would be of interest, particularly since there is a relationship to the development of service programs. In order to view the conference in this way, the following material provides a descriptive narrative around a particular T.A.P. and attempts to demonstrate: (1) The T.A.P. is not isolated from the rest of a clinical program; (2) Its relative success and value depends on events leading to its development and can be measured, in part, by post-conference events.

In January, 1958, a Conference on Mental Health Principles in School Guidance Programs was held at Newport, Rhode Island. The conference theme was *The Underachieving Child*. This workshop, supported as a T.A.P. from the National Institute of Mental Health, was sponsored locally by Rhode Island Mental Hygiene Services and the State Department of Education. Since the existence of the T.A.P. program was known eighteen months prior to the conference, what were the events leading up to the opportunity for this particular project?

In the winter of 1957, a citizens' committee from Warwick, Rhode Island, was exploring the various mental health facilities available in Rhode Island in order eventually to provide more clinical service to Warwick citizens. This committee, while visiting Mental Hygiene Services, learned that, in addition to clinical services already available, we were in a position to provide consultation service on request. Within a week there was a request to meet regularly with the school guidance personnel. This program began in March of 1957, and continued weekly for the remaining school year. It was through the enthusiasm of this group, and their expressed desire

*continued on next page*

that similar information be made available to other guidance personnel, that the idea of a statewide conference was proposed. Since a member of the staff of the State Department of Education had been a participant observer during the weekly meetings, joint sponsorship of the workshop was easily arranged.

During the period of preliminary arrangements, contacts developed between Mental Hygiene Services and educators that had not existed before. The commissioner of education announced the workshop to the superintendents, who selected their guidance personnel and forwarded applications to Mental Hygiene Services. The same announcement, had it come from Mental Hygiene Services would probably not have had as quick response as it received when it came from the commissioner. Ninety per cent of the applications were returned in two weeks. The joint sponsorship also brought about a closer practical working relationship between Mental Hygiene Services and the Department of Education personnel. The representative of the Education Department was of inestimable assistance in assuring complete and equal statewide distribution of participants and also in arranging the workshop groups according to school areas to facilitate future area meetings on the conference subject of *The Underachieving Child*.

The Conference also afforded an opportunity for the guidance counselors to meet as a common group. In the course of their regular schedule they seldom have time to meet and review their mutual problems. In many cases, in the smaller school systems, the single guidance counselor becomes quite isolated. The conference was instrumental in making a number of educators personally aware of the existence of Mental Hygiene Services and its clinical program. Interspersed with conference subject matter were a number of questions asked about our service, particularly concerning method of referral. Subsequent to the conference there have been a number of new referrals directly related to conference participants who had never previously used our service.

Concurrent with events directly related to the conference were certain parallel developments. Even before the workshop began, the knowledge of the T.A.P. stimulated the personnel of the State Division of Alcoholism to plan for a T.A.P. conference on alcoholism and industry, which took place in June, 1958. Mental Hygiene Services' staff were in a position to assist Division of Alcoholism personnel in their plans and thereby improve relationships between two agencies in the larger Department of Social Welfare.

A parallel movement more directly related to the T.A.P., which shows the continuity of events before and after the workshop, is the development of the

clinical service provided by Mental Hygiene Services in the Newport area. During the three years prior to the T.A.P., the traveling clinic of Mental Hygiene Services in Newport had gradually grown from a semimonthly clinic to a weekly service. By the end of 1957, there was a definite indication the clinic had outgrown its available quarters and that more than one day weekly would be necessary to meet the increasing requests for service. The largest number of referrals in the Newport area had been from the school department; but prior to the T.A.P., the clinic staff had not had direct contact with the guidance personnel in that city. The personal acquaintances developed at the conference led the Newport guidance counselors to request a meeting with Mental Hygiene Services' staff to discuss the needs for more space and clinic time. After three meetings, it was agreed the school department would provide the additional space we needed and also some clerical help, with the understanding the clinic would continue to be an all-purpose community clinic and not limited solely to school referrals. Mental Hygiene Services, in turn, would increase the available team time from one day weekly to twice a week and, if warranted, would consider expanding the service to three days weekly in the future. Especially desired by the guidance counselors, and agreeable to Mental Hygiene Services, was a request that the psychiatric social worker act as direct liaison between the counselors and Mental Hygiene Services for continuing consultation.

This general outline of events indicates how a T.A.P. evolves from an ongoing service program to meet a particular need. At the same time, there is a direct effect on all parties involved, bringing about a closer relationship between sponsoring agencies and a broader understanding on the part of the participants, not only for workshop content but also an awareness of the total service program. In this case, participants were later instrumental in helping to expand clinic services. This bonus effect had not been expected or planned.

At this writing there are indirect benefits of unknown degree still to accrue through the distribution of the proceedings of the conference. In addition to the participants, copies have been sent to all guidance personnel in the state, all principals and superintendents in the elementary and secondary schools, as well as to key educators in the local colleges and universities and nursing and casework agencies working with children. An intangible gain was the opportunity, through the conference, for the participants to meet and know personally representatives of the regional staff of the Department of Health, Education, and Welfare. The distribution of the conference proceedings by the National Institute of Mental Health to the various state mental



## A NEW CONCEPT IN IMPLANT DENTISTRY WITH A PRELIMINARY REPORT OF FOUR CASES

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The Author, *Milton Hodosh, D.M.D., Assistant Dental Surgeon, Outpatient Department, Rhode Island Hospital, Providence, Rhode Island.*

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THIS STUDY involves an approach to prosthetic dentistry which could provide the means of giving to the edentulous or partially edentulous individuals "third teeth," that are artificially placed, and cosmetically as well as physiologically functional.

### *Specific First Phase Aims*

1. To determine whether plastic teeth reproduced in shape, color, form, and dimension of freshly extracted teeth could be placed into and biologically accepted by human alveolar sockets without untoward reaction.

2. To determine whether a mechanical union could be created between the plastic implants and bone by blood clots forming in previously cut holes and depressions of the roots of the plastic teeth. The hope was that blood clot, organization, callus formation, calcification and subsequent formation of mature bone would ensue as in fracture healing.

### *General Technique Used*

Under local anesthesia, a human tooth requiring extraction was removed, taking care not to damage buccal or lingual bone and not to fracture the tooth if possible. Defects in the crown due to caries or to other destructive phenomenon were corrected with wax. A mold was made by investing the corrected natural tooth in plaster. The mold was heated for ten minutes in clean boiling water and then opened. The wax used for coronal correction and revision was removed by pouring boiling water over the hot mold. The tooth was removed from the mold and vaseline applied as a separating medium. The plastic powder and liquid was mixed by definite proportions and was allowed to reach a doughy consistency and was packed and pressed into the mold. The mold containing the plastic was heat processed for fifteen minutes, then cooled and opened. The plastic tooth was removed, finished down, and polished smooth with pumice. Holes and depressions were cut in the root of the plastic tooth, some even through and through. The exact sites of the holes and depres-

sions depend upon the root anatomy and vary with principles of leverage and mechanical retention. The alveolar sockets were gently curetted to attain slight hemorrhage. The plastic tooth which had been previously placed in aqueous zephirin for mild sterilization was inserted into the bleeding alveolus, taking care not to touch the root area to be imbedded. The implanted plastic tooth was splinted by a method to be described in the specific report of cases.

### *Report of Plastic Tooth Implants*

The patients are volunteers referred from the adult out-patient department of the Rhode Island Hospital. The first patient is a well-developed and well-nourished negro male, twenty-three years of age. His medical history is noncontributory. He had two teeth that required replacement. They were the maxillary left second bicuspid and maxillary right first bicuspid. The technique used was the same as described in the preceding paragraphs. In both cases acrylic was used. The first plastic tooth implant was the left maxillary second bicuspid. The natural tooth was extracted. By vibrating the tooth downward with forceps, and then using the usual buccal-lingual movements the danger of the tooth and bone fracture was minimized. The tooth was corrected, reproduced in form, color, dimension, and then inserted into the alveolus. The implant was extremely firm and no splinting was used. The patient was free of pain, infection, or any other noticeable reaction. He stated, "That it feels like the rest of my teeth." However, at the end of three weeks he had eaten on the implant so vigorously that it became slightly loosened. The plastic implant was splinted with 26-gauge stainless steel wires and it subsequently became firm again. This demonstrated that excessive stress must be removed from the implant by splinting in order to allow adequate bone to form.

In the second case, the maxillary right first bicuspid was acutely abscessed. The patient was placed on tablets of penicillin, 200,000 units three times a day for five days. An incision and drainage was performed in the muco-buccal fold. Chronicity was established and a fistula developed on the buccal aspect of the tooth. Five weeks passed. The patient had broken the buccal cusp of this tooth during

*concluded on next page*



this period. The clinical crown of the natural tooth was restored in wax. The wax removed, the tooth extracted and the wax then added back to the tooth. By methods previously described, the plastic tooth was made, inserted, and due to the experience of the first implant, splinting was done.

On March 15, 1959, two plastic implants were performed. One, on an eighteen-year-old white, well-developed and well-nourished female. The tooth involved was the lower right, second bicuspid. The other, the lower right first molar was done on a twenty-one-year-old white, well-developed and well-nourished male. Both medical histories were noncontributory. Both teeth had periapical pathology by X-ray observation and the first molar was acutely infected. An incision and drainage was done in the right muco-buccal fold area and the patient placed on penicillin therapy. The procedures for these two implants were done as stated in the preceding paragraphs. There was one slight variation, and that was in the method of heat processing the plastic. In these cases dry heat was used instead of boiling.

### *The Method of Splinting*

A groove was cut on the occlusal surface of the upper right second bicuspid and the implant with a fissure bur. With an inverted cone bur the grooves were undercut and deepened. Twenty-six-gauge stainless steel wire was braided and cut to proper size and shaped to fit into the grooves. Quick setting acrylic was placed into the prepared grooves and the braided wire was placed into position. More quick-setting acrylic was applied over the wire and allowed to harden. When hardened the excess acrylic was removed to correct occlusion. This type of splinting has the advantage of having no wires to irritate the gingiva or trap food, and may be left for months and possibly indefinitely. It may be kept hygienically clean. This splint was found to be good for it remained firm. The other wire splint loosened and irritated the gingiva somewhat. An acrylic occlusal wire splint was also placed on the maxillary left first bicuspid, the first maxillary permanent molar, and the maxillary left second bicuspid implant.

In all cases penicillin therapy was administered for five days. White blood counts are to be done three times yearly to determine whether any infection exists. X rays and Kodochrome slides are taken periodically. Every three to six months, the patient is examined by the tumor clinic director of the Rhode Island Hospital to rule out any possibility of the implants being carcinogenic agents.

### *Results*

The first plastic tooth implant was inserted November 11, 1958, and the second was inserted

December 28, 1958. X rays taken on January 29, 1959, disclosed both clearly to have substantial bone or bone-like substance formation at the sites where holes and depressions were cut prior to implanting plastic teeth. This, of course, is very gratifying. A W.B.C. taken November 21, 1958, was within normal limits, indicating the absence of infection.

The third and fourth implants were inserted on March 15, 1959, and appear to be progressing well clinically.

The patients have been free of pain, and to date the implants have been well tolerated, and appear to be producing no untoward reaction. The gingivae have adapted excellently at the cemento-enamel junction of the implants and the patients are functionally comfortable and cosmetically satisfied.

More cases are being done and additional results are being obtained. This paper has been written to inform others of the notable results obtained to date. Further details will follow as the study continues.

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MILTON HODOSH, D.M.D.

### TECHNICAL ASSISTANCE PROJECTS FOR MENTAL HEALTH

*concluded from page 252*

health programs will have wide value which may never be known to us directly.

### SUMMARY

The T.A.P. is a useful, efficient, and economical method of extending the consultation services of the regional office staff of the Department of Health, Education, and Welfare. It is helpful to state programs by providing the means to conduct a specific conference somewhat broader in scope than is possible within the regular program budget.

This type of conference plays an active and important role in the development of regular service programs. A conference does not exist in vacuo, but evolves from a series of events both in the community at large and the sponsoring agencies. The post-conference events have a direct and indirect relationship to clinical services and mental health education programs. The distribution of conference proceedings extends the value of the meeting far beyond the borders of the sponsoring state. Since a T.A.P. has such far-reaching, positive effects, it is to be hoped support for this program will be continued and expanded in the future.

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## QUACKERY IN THE DAILY PRESS

A ONE-WEEK CHECK of a prominent daily newspaper, covering the Sunday and six evening editions, revealed no less than thirty-three advertisements promoting patent medicines, nostrums, trusses, alleged weight-reducing pills, and various kinds of apparatus. This flood of quackery continues unabated. The following paragraph contains a fair sampling of the sort of rubbish to which the public is exposed:

Gassy? Three Times Faster Relief. . . . Tired Blood: Feel Stronger Fast. . . . What Doctors Approve for Child's Head Cold. . . . Live a "regular" life—without laxatives. . . . You'd Never Know I Had Psoriasis. . . . Quickly Relieves Misery of Chest Cold. . . . How you can break the Vicious Cycle of Nervous Tension Headaches: better than aspirin even with buffering added. . . . Amazing new Discovery is made by doctors who looked inside a living person's stomach. . . . Guarantees Exquisitely Soft, Smooth Skin. . . . Asthma Formula Prescribed by Doctors—Available Now Without Prescription: Stops Attacks in Minutes. . . . Forget Ruptures: Troubles with Reducible Rupture Gone. . . . Victory Over Psoriasis Attacks. . . . I reduced 46 lbs. without dieting! . . . They Re-grew Hair! . . . Protect Your Heart! . . . Relieves upset stomach. . . . Sure Way to Stop Itching or Skin Rash. . . . Can't Sleep? 100% Safe Sleep. . . . Night Cough Relieved without Codeine. . . . Periodic Pain: Don't let the calendar make a slave of you. . . . Stop Skin Torment. . . . Don't let Constipation Add to Your Worries! . . . Stop Pimples! . . . Massagers Help

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The fact that many of the preparations thus touted contain innocuous drugs or even inactive ingredients does not necessarily make them harmless. Aside from the vast sums of money wasted by the public on these nostrums, the greater evil in the patent medicine racket is its encouragement of self-diagnosis and self-treatment. Enumeration of some of the inherent dangers will bear this out. Gaseous distention, belching and "acid indigestion" may presage ulcer, cancer or biliary disease. Anemia (we call it tired blood) may be caused by malnutrition, blood loss or even pernicious anemia itself. Irregularity may be the result of bowel obstruction due to carcinoma. Headaches may be caused by optical refractive errors requiring glasses, by hypertension or even by brain tumor. Aspirin, buffered or unbuffered, will not correct these serious defects. Skin problems may reflect important systemic medical disease. Itching, for example, may be caused by jaundice or by lymphoma. Psoriasis, notoriously difficult to treat, can be tricky to diagnose. Asthma may be the result of allergies amenable to treatment; so-called asthma may actually be dyspnea due to congestive heart failure. A cough can be caused by tuberculosis or cancer of the lung.

It is quite generally conceded that with very few exceptions ruptures require surgical correction; trusses do not prevent hernial strangulation and they weaken tissues rendering later surgical management much more difficult. Weight reduction, certainly when of major proportions, should always

*continued on next page*

be carried out under the supervision of a physician. Thyroid-containing pills are fortunately not now generally available, but anorectics may be equally dangerous for some patients. As a matter of fact, most proprietary weight-reducing preparations are either dangerous or completely inactive and useless and thus sold under false pretenses. Weight-reducing apparatus is sheer delusion.

Aside from the matter of propriety and taste, important questions may legitimately be asked about the justification for carrying this sort of advertising. Any contention that it is not improper because it is legal certainly need not be refuted. The Food and Drug Administration and the Federal Trade Commission have worked hard and with considerable success to protect the public from the worst abuses and the greatest dangers. Both agencies, however, are handicapped by litigation and by legal loopholes perpetuated by the sophistry and guile of politicians and the unlimited riches of the patent medicine lobby.

We would hope that we have outlived the doctrine of *caveat emptor*. In other fields a considerable degree of policing is in evidence, as exemplified by the non-official Better Business Bureaus and, among Government Agencies, the Securities and Exchange Commission.

The frightened, the ill, the unwary, the naive, and the uninformed certainly deserve more protection than they are getting against the onslaught of cynical advertising and a rapacious patent medicine industry. That television is worse does not excuse our daily newspapers. The daily press has assumed with increasing vigor, if not always with the best of judgment, the grave responsibility of informing the public through its news columns about medical scientific progress. It has not always been sympathetic toward the medical profession in debating editorially problems of social significance relating to the practice of medicine. A daily press that preaches perfection in its news and editorial columns would do well to search its conscience. The august and respected NEW YORK TIMES has long set a fine example by demonstrating that it can prosper and yet exclude from its advertising columns this seamy and posterous material.

### POLIOMYELITIS PERSISTS

To hail the discovery of a method of prevention of a dreaded disease, honor the person chiefly involved in consummating the discovery, and then to forget the whole matter gets us nowhere. Recent reports suggest that this is far too nearly the course that is being followed regarding paralytic poliomyelitis. Doctor Norman C. Kiefer, president of the National Health Council, is quoted in the NEW YORK TIMES, of March 1, as saying that after the Salk Vaccine had been evaluated as "safe, potent

and effective" the number of cases of poliomyelitis had declined from nearly 39,000 in 1954 to 5,485 in 1957. "But last year," Doctor Kiefer continued, "despite all the efforts of the National Foundation, the American Medical Association and the United States Public Health Service . . . for the first time since the use of the vaccine there was an upward turn in polio cases. There was a recurrence of epidemics and, tragically, the incidence of the paralytic form of the disease rose 44 per cent over the 1957 figure."

In 1958, 5,995 cases were reported, of which 3,083 were paralytic. The reason for this seems to be that there has been a general neglect on the part of physicians to suggest, and the public to seek this obviously effective method of prevention. Doctor Kiefer pointed out that more than half of the population of the United States had not been inoculated with the Salk Vaccine. Epidemics of the disease may be expected which, he stated, "might be even greater than those that occurred last summer in Michigan, New Jersey, Texas, Montana, Virginia, West Virginia and Hawaii." Of 24 million children under six years of age, it was estimated by Doctor Robert J. Anderson, of the United States Public Health Service, that not more than half had received a full series of Salk vaccinations.

It is easy to realize what the smallpox situation would be in this country had the work of Doctor Jenner been as poorly applied as is that of the investigators of poliomyelitis — Doctor Salk and his colleagues in the field. Rhode Island is a small, compact unit of geography and population. Would it not be well for our state, as it has done in certain other matters concerning public health, to lead the way in this field, and by conscientious and complete application of this effective and readily available method of prophylaxis to show that the menace of paralytic poliomyelitis, which is still with us, can be defeated?

### MICHAEL HENRY SULLIVAN, M.D.

In 1900, a vigorous young man, Michael Henry Sullivan, was graduated *cum laude* from the Harvard Medical School. He served his internship at the Carney Hospital in Boston, returned to practice in his native city of Newport, and through fifty-eight years so endeared himself to everyone that when he died at eighty-one, a whole city fell into mourning, for his patients realized sadly that never again could they summon, night or day, the best of friends, their skillful, kindly, devoted family doctor who brought comfort when he could not bring healing.

Doctor Sullivan began his medical career, and ended it, as a general practitioner; he would not have had it otherwise. His medical work was his life, especially his work in obstetrics. It is hard to

*concluded on page 258*



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1. Based on six-month National Physicians Survey.



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## MICHAEL HENRY SULLIVAN, M.D.

*concluded from page 256*

believe, and yet it is true that he delivered 18,000 babies — an extraordinary accomplishment. There are women in Newport whom he brought into the world and whom he continued to treat when they themselves had become grandmothers. His welcome was as cordial in the palaces on Bellevue Avenue as in the more plebeian parts of the city, and in token of their high esteem, his fellow-citizens gave his name to one of their elementary schools.

Six years ago, the Rhode Island Medical Society selected him as the Rhode Island Practitioner of the Year. Conferring this honor upon him the Society said, "In you the Rhode Island Medical Society notes all the qualifications of greatness that mark you as a leader in your profession, and above all as a practitioner of the healing art who has given unselfishly of himself to render services to all individuals, rich and poor alike, all creeds and nationalities, in your County of Newport for more than fifty years."

Despite serious surgical operations and uncertain health in his later years, he nevertheless continued his practice with the courageous devotion which always marked his indomitable spirit. Michael Sullivan was an honored and honorable physician who embodied the best traditions of the profession he loved so well.

## UNDERGROUND WIRES—A SUGGESTION

The ice storm of February 10, 1959, so costly to Southern New England, was not unusual; each winter there is one or more of these which New Englanders have come to expect. The interruption of electric and telephone service during these storms is many times very serious, but, of necessity, we have accepted these interruptions together with the dangers and financial hardships which accompany the breakdown of electric and telephone services.

If the electric and telephone wires were put underground, damage by wind, rain, sleet and snow would be tremendously reduced. This would also restore the natural beauty of the landscape and the sky so often ruined by the accumulation of poles, wires and cables which run helter-skelter across our fields of vision with little or no regard for the demands of beauty or even of utility. Certainly, it would be expensive to put the wires underground, but by what method can one measure the money cost against the loss of property and the danger to human life and health which occur in Rhode Island several times each year? In the long run, the savings would be considerable in money, time and convenience, but most important of all in the conservation of public health. Replacement of old worn-

out overhead poles by underground electric and telephone wiring could be done gradually in accordance with a definite plan which could be carried out at the time of construction, in all new housing and industrial areas. Of course, it is helpful to have the national and state governments contribute millions of dollars of our own tax money for the construction of a hurricane dam in Narragansett Bay, but that would solve only a small part of this complex problem. Like charity, protection of personal property and of health should begin at home; and what is closer to home than the telephone and the electric light?

## MEDICARE BILLINGS

The Offices for Dependents' Medical Care has issued the following notice relative to Medicare billings:

1. **DELAY IN MEDICARE BILLINGS** — This office is concerned about the receipt of a large number of claims which have been delayed for a considerable period of time after completion of care. Delayed billings cause many problems for the Government, the contractors, the dependent or sponsor, and the source of care, all of whom are interested in settling the matter of payment as soon as practicable. From the Government's standpoint, the timely receipt of claims is most important in that the information therefrom is used as the basis for budgetary requests and other required statistical data.

2. **FUTURE CLAIMS** — It is emphasized that Medicare contracts call for payment to be made on the basis of "complete" claims. Hospitals and physicians are urged to obtain all of the necessary information, including the Medicare Permit if required, or make arrangements for obtaining same, at the time the patient makes the initial visit and at the time the understanding is reached that care will be rendered under the Medicare Program. It is particularly important to examine the DD Form 1173 (Uniformed Services Identification and Privilege Card) and to obtain and record the required information therefrom, or to obtain adequate documentation establishing that the patient is an eligible dependent of an active duty member of the Uniformed Services. Physicians and hospitals are urged to submit claims as soon as care has been terminated. This will assist in cutting down correspondence required to complete the information necessary on the Claim Form for payment. With the passage of time, records may be misplaced and difficulty experienced in assembling all of the information required to submit a "complete" claim. Also, with the passage of time, the serviceman may be discharged or reassigned and he and the dependent may leave the area where care was received. In some cases, difficulty is encountered by the Uniformed Services in contacting the reassigned member or a former serviceman and his dependents after discharge.

3. **OLD CLAIMS** — For the same reasons outlined above, physicians and hospitals are urged to "complete" and submit old claims, on hand, as soon as practicable. With the passage of time, it will become more and more difficult to process these claims and resolve difficulties which may arise in connection with them.



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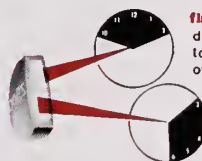
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## RHODE ISLAND PHYSICIANS GIVE MORE THAN \$500,000 FREE SERVICE TO PUBLIC ASSISTANCE RECIPIENTS

In his report to the Special Commission named to appraise the financial operations of the state government and the matter of state-local financial relations, George E. Bigge, consultant, in his survey of the Rhode Island Department of Social Welfare, noted the outstanding co-operation rendered by the physicians of Rhode Island in rendering medical care to beneficiaries of the program. The following abstract from the survey report illustrates the great contribution of the medical profession.

... THE EDITORS

\* \* \*

IT IS CLEAR that the quantitative standards and the fee schedules in effect are not unduly liberal. The office of Medical Services appears to have been successful in securing the co-operation of the profession in the development of reasonable standards. The director of Medical Services points out, too, that in addition to providing services at relatively low rates, under the regular program, many physicians give medical care for which no bills are presented. Also, they continue to render free services at hospitals which benefit the recipients of public assistance. In another connection the director enumerated these free services to public assistance recipients (exclusive of GPA) in Rhode Island during the year 1956-57 as follows:

Services	Reasonable Fees	Total Value
46,000 hospital visits at _____	\$ 5.00	\$230,000
887 surgical .....	130.00	133,000
275 tonsils and adenoids .....	65.00	17,875
130 deliveries .....	130.00	50,570
42 D. & C. ....	62.00	2,604
29,350 O.P.D. Services .....	3.00	88,050
<i>Total free services to P.A. recipients .....</i>		<i>\$522,099</i>

These figures are cited by the director as further evidence that the professions are co-operating wholeheartedly in attempting to provide medical care at reasonable cost to the state.

"In the field of medical care it is difficult to find comparable experience in other states with which to compare the experience in Rhode Island. Many states provide only minimum care. Only twelve states have undertaken to provide comprehensive services such as Rhode Island provides. In general, the cost in these states is relatively high. Five of the New England States have fairly comprehensive programs, particularly for the aged and disabled. Available statistics generally do not include expenditures in connection with general public assistance. This program does not ordinarily provide the kind of medical care that is available in connec-

tion with the categorical programs. This is commonly taken care of through the local welfare office. In Rhode Island, too, payments are made through the local office, but the same standards and fees are applicable to GPA as to the other programs. However, the following figures for Rhode Island as for the other states are based on the four federal-state programs. The monthly payments for medical care, whether through the pooled fund or otherwise in the New England States in August 1958 were as follows:

State	OAA	ADC	AB	AD
Connecticut	\$20.00	\$6.09	\$16.00	\$35.00
Maine	7.50	.86	6.00	12.00
Massachusetts	19.77	3.32	1.50	33.53
New Hampshire	15.00	3.98	11.00	30.00
Rhode Island	11.00	4.38	6.00	14.00

"It appears from this tabulation that expenditures for medical care in Rhode Island are decidedly reasonable compared with those in neighboring states. The director of Medical Services is convinced that the services rendered are fully as good as in other states. The relatively low expenditures he attributes to close co-operation with the professional societies which has enabled him to set standards and fees which are extremely reasonable, and to the careful supervision of the program. This supervision assures the large majority of practitioners who are willing to co-operate that the standards will be applied in all cases for the benefit of the community, and is largely responsible for the continuing support of the program by the professional groups.

"From such investigation as he has been able to make, your consultant is persuaded that for Rhode Island, under its present direction, the medical care program is rendering effective service and is operating economically. The director's standing as a practicing physician and his close co-operation with the profession has enabled him, up to the present time at least, to get the support of the professions both in setting standards and in applying them to individual situations. The small size of the state makes it possible for him to check all claims individually. This gives uniformity and continuity to the program and enables him to exercise personal judgment in connection with marginal cases. Whether a similar system could be made to work in another, larger state, or under different circumstances, need not concern us at the present time. For Rhode Island, today, it seems to work well. Your consultant has no recommendation to make in this connection."

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## MOSES MAIMONIDES

## A Book Review

SEEBERT J. GOLDOWSKY, M.D.

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The Author, *Seebert J. Goldowsky, M.D., Associate Editor, R. I. Medical Journal; Surgeon, Miriam Hospital; Assistant Surgeon, Rhode Island Hospital.*

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RABBI MOSES BEN MAIMON, Hebrew scholar, physician, and philosopher, was born in Spain in 1135 and died in Cairo in 1204. Because of persecution he was forced to leave his native Cordoba, moving first to southern Spain and later to Fez, Morocco. While there he studied medicine with several famous Arab physicians. At the age of thirty he finally settled in Egypt, where he carried on a large medical practice and pursued his literary career with increasing fame. He is said to have refused an offer tendered by King Richard the Lion Hearted to accompany him to England as court physician. His greatest scholastic effort was his endeavor to organize and systematize the great mass of Jewish oral law into a reference work useful to layman as well as to rabbis and judges. He produced, in addition, a work on logic, a treatise on the calendar, a great philosophical work on the Bible, and several medical monographs.

THE PRESERVATION OF YOUTH,\* written in Arabic in 1198, was commissioned by Sultan Al Afdal, son of Saladin, for his own use. Although it had been translated into Hebrew in 1244 and into Latin in 1290, the present translation is the first into the English language. His medical thinking was influenced greatly by the ancient Greeks and by Arabic sources, but his own wisdom and surprisingly modern insight shine through. He had no patience with the supernatural in medicine. The following excerpts from the excellent translation are aphoristic in their succinctness:

"The preservation of health is the abstaining from over-satiation and from the breakdown due to fatigue. . . .

"The warmer the temperature, the less should be the quantity [of food]. . . .

"If a man would take care of his body as he

takes care of the animal he rides on, he would be spared many serious ailments. For you will not find a man who would give too much hay to his animal, but he measures it according to capacity. However, he himself will eat too much without measure and consideration. . . .

"One does not consider exercise though it is the main principle in keeping one's health and in the repulsion of most illnesses. . . .

"Fools think that a man needs a physician during his sickness only and at no other time. . . .

"Most physicians commit many errors and, while they think they increase the patient's strength, they really weaken him and interfere with his progress. . . .

"One should select as attendants and caretakers those who can cheer up the patient. This is a must in every illness. . . .

"One should use medications compounded of multiple ingredients only when compelled to do so. . . .

"Emotional experiences cause marked changes in the body which are clear and visible to all. . . .

"The reactions of all those who fear and hope and anticipate security and calm are well known, as are also the various reactions in the thoughts of those who are desperate or successful. . . .

"The more a man is disciplined, the less he is affected by both extremes, good times and bad. . . .

"The quality of urban air compared to the air in the deserts and forests is like thick and turbulent water compared to pure and light water. . . . Since there is no way out, because we grew up in cities and became used to them, we can at least choose a city with an open horizon. . . .

"One should place the privy as far as possible from his permanent residence. . . .

"Many physicians treat their patients with criminal neglect; nevertheless the patients do not die but are saved. . . .

"The error of the physicians is equal in both directions, for sometimes they commit a grave error and the patient is saved, and occasionally the error is very mild and the patient thinks that it is of little consequence, yet it will prove the cause of his death. . . .

---

\*THE PRESERVATION OF YOUTH, by Moses Ben Maimon (Maimonides). Translated from the Original Arabic (Fi Tadbir As-Sihha) and with an introduction by Hirsch L. Gordon, M.D., PH.D., D.H.L., Philosophical Library, New York, 1958. \$2.75.



"The more perfect a person becomes in one of the sciences, the more cautious he grows, developing doubts, questions and problems that are only partially solved. . . .

"The more deficient one is in science, the easier it will be for him to understand every difficulty, making the improbable probable and increasing the false claims which he represents as certain knowledge, and is eager to explain things that he does not understand himself. . . .

"The benefits of wine are many if it is taken in the proper amount, as it keeps the body healthy and cures many illnesses. . . .

"The bath is very necessary for the maintenance of health and for the cure of disease. . . .

"One must avoid, at any place and at any time, partaking of a food which has begun to decompose even slightly. . . .

"Habit and regularity are great principles for keeping well and recovering from illness. . . ."

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
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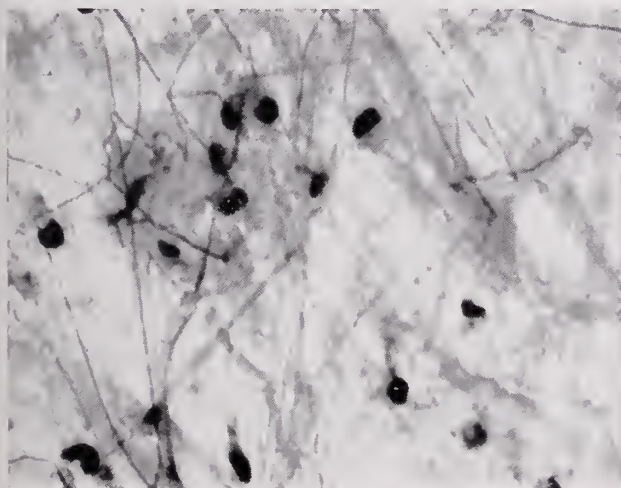
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Ascorbic Acid . . . . .	20 mg.

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## DISTRICT MEDICAL SOCIETY MEETINGS

### PAWTUCKET MEDICAL ASSOCIATION

The annual meeting of the Pawtucket Medical Association was called to order by Doctor Edwin Lovering at 11:00 A.M., on March 18, 1959, in the Nurses' Auditorium of the Pawtucket Memorial Hospital. Twenty-three members of the Association were present.

The reading of the minutes of the previous meeting was suspended. The annual treasurer's report was accepted as read by Doctor Rocco Bruno. There was no report from the standing committee.

The annual president's address was delivered by Doctor Edwin Lovering, who thanked the officers and members of the association for their support throughout the year. In his address Doctor Lovering commented upon the programs that were held throughout the preceding year by the group and suggested that in the future more attention might be directed toward the economic aspects of medicine. Specifically, an attempt should be made to investigate the tax exemption privileges of physicians. Doctor Lovering also spoke of the role of the nominating committee. He suggested it would be a more democratic procedure if more than one slate of candidates be proposed so that the voting members would have a choice in selecting these officers.

The report of the nominating committee was submitted by Doctor Harold Woodcome, chairman. The nominees were:

*President* ..... RUDOLPH JAWORSKI, M.D.  
*Vice-President* ..... EUGENE GAUDET, M.D.  
*Secretary* ..... JOHN CUNNINGHAM, M.D.  
*Treasurer* ..... ROCCO BRUNO, M.D.  
*Delegates to Rhode Island Medical Society*—EARL KELLY, M.D.; ROBERT HAYES, M.D.; FERDINAND FORGIEL, M.D.; ALEXANDER JAWORSKI, M.D.; HARRY HECKER, M.D.

*Councilor* ..... EARL MARA, M.D.  
*Alternate Councilor* ..... HENRY HANLEY, M.D.

A motion was made and carried that the secretary cast one vote for this slate.

Doctor Jaworski was escorted to the president's chair by Doctor Albert Foster.

Doctor Jaworski announced that the appointment of committees would be made at a later date.

Under new business, there was considerable discussion of sickness and accident coverage for the members of the Association. Doctor Edward Horan

suggested that perhaps a local carrier could be found to handle such a program. Doctor Earl Mara felt that an investigation might be made into the possibility of the Association itself insuring its members. The whole matter was referred to the economic committee for further study.

Motion was made by Doctor Lovering and carried that the annual assessment remain the same (\$25.00). There followed a general discussion as to the best time to hold the monthly meetings. It was decided that the president should poll the membership about the matter. The issue was then referred to the standing committee.

The meeting was adjourned at 12 noon.

Respectfully submitted,

JOHN J. CUNNINGHAM, M.D., *Secretary*

### PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, March 2, 1959. The meeting was called to order by the president, Doctor John C. Ham, at 8:35 P.M.

The reading of the minutes of the previous meeting was omitted.

#### *Report of the Secretary*

Doctor Michael DiMaio, secretary, reported as follows:

At a recent meeting of the Executive Committee, among other matters, the following actions were taken:

1. The resignation of Doctor Carmelo Addario was accepted as the doctor has now taken residence in Italy.
2. The financial report of the Medical Milk Commission of the Association, for the fiscal year 1958, was reviewed and found in order.
3. The Entertainment Committee was authorized to proceed with its plans for the Annual Dinner and Golf Tournament, to be held on Wednesday, June 24.
4. The Executive Committee voted not to reappoint a Liaison Committee of the Association with the Board of Directors of Physicians Service as this Committee has been inactive in the past two years.

It was moved that the report of the secretary be

*concluded on page 268*

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## PROVIDENCE MEDICAL ASSOCIATION

*concluded from page 266*

received and placed on file. The motion was seconded and adopted.

*Announcements*

The president called attention to the Cancer Conference for Rhode Island Physicians to be held at the Medical Library on March 18, and to the April 6 meeting of the Providence Medical Association at which Justice Aron Steuer of New York and Doctor Howard Craig will discuss *Medical Aspects of the New York Medical Testimony Project*.

*Election of Members*

The secretary reported that the Executive Committee recommended for election to active membership in the Association the following: Leo A. Coleman, M.D.; Max Fainty, M.D.; Manoel Falcao, M.D.; Wolfram H. Fischer, M.D.; Thomas E. Hunt, M.D., and Daniel Massouda, M.D.

**ACTION:** It was moved that these physicians be elected to active membership. The motion was seconded and adopted.

*Scientific Program*

The president introduced Doctor Herbert S. Sise, Director, Circulation Laboratory, Boston City Hospital, who spoke on *Anticoagulants in Cardiovascular Disease*.

*Adjournment*

The meeting adjourned at 9:40 P.M.

Attendance was 88.

Collation was served.

Respectfully submitted,

MICHAEL DiMAIO, M.D., *Secretary*

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## SCHEDULE OF DISTRICT SOCIETY MEETINGS

*Bristol County Medical Society**Day:* Third Tuesday*When:* Every other month, or as needed*Time:* 8:30 P.M.*Place held:* Either Warren or Bristol, as pre-arranged*Kent County Medical Society**Day:* Not set*When:* Quarterly*Time:* 9:00 P.M.*Place held:* Kent County Hospital*Newport County Medical Society**Day:* Second Wednesday*When:* Every other month, February through December*Time:* Dinner 7:00 P.M., meeting follows*Place held:* Hotel Viking or Shamrock Cliff*Pawtucket Medical Association**Day:* Third Thursday*When:* Except July and August*Time:* 6:30 P.M., cocktails; 7:30 P.M., dinner*Place held:* Lindsay Tavern*Providence Medical Association**Day:* First Monday*When:* October-April inclusive*Time:* 8:30 P.M.*Place held:* Rhode Island Medical Society Library*Washington County Medical Society**Day:* Second Wednesday*When:* Quarterly, January, April, June, October*Time:* 11:00 A.M.*Place held:* Location varies*Woonsocket District Medical Society**Day:* First Tuesday after second Monday*When:* Quarterly, or as needed*Time:* 8:30 P.M.*Place held:* Woonsocket Hospital Cafeteria

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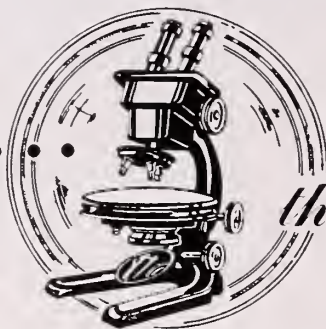
"Drink to the  
general joy of the  
whole table."

— Shakespeare

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# THROUGH .



# the Microscope

## *Scholarship Available for Trudeau School*

The Rhode Island Tuberculosis and Health Association is again offering a Christmas Seal scholarship of \$500 to a Rhode Island physician to permit him to attend the forty-fourth session of the Trudeau School of Tuberculosis to be held at Saranac Lake, New York, June 8-26. The recipient will be chosen by the Association's board of directors, and applications for the local scholarship must be filed by May 1. Other scholarships are available directly from the Trudeau School for those physicians who qualify.

## *Medicine at the Seashore*

Some 15,000 physicians will gather in Atlantic City, New Jersey, next June 8-12 for the 108th annual meeting of the American Medical Association.

Besides physicians, the meeting will be attended by residents, interns, nurses, technicians, students, and physicians' wives and members of their families.

The five-day convention — the largest medical meeting in the world — is being held in Atlantic City for the sixteenth time. The first meeting was held there in 1900.

Doctors will have the opportunity to catch up on hundreds of aspects of a rapidly changing medical world. This information will be presented in the form of scientific exhibits, lectures, motion pictures, panel discussions, televised surgical procedures, and industrial exhibits.

New medical research findings and methods of handling daily medical problems will be reported by 500 physicians in scientific papers or participation in symposia and discussion groups.

There will be over 300 scientific exhibits and a similar number of industrial exhibits on display at the famed Convention Hall. The latter group will be exhibited by pharmaceutical houses, medical equipment firms, and other manufacturers.

## *Fitness Requirements of Motorists Established*

A new guide to assist physicians in determining

the fitness of motorists to drive was released last month by the A.M.A., through its committee on medical aspects of automobile injuries and deaths. In general, an individual should be assessed medically to determine the answers to the following questions, according to the Committee:

—Has the patient any physical and mental ability to manipulate the controls?

—Is the patient likely to suffer excessive fatigue that will impair his driving ability?

—Does the patient have the required vision and hearing for safe driving?

—Has the patient any physical or mental disorder likely to cause confusion or a sudden loss of consciousness while driving?

—Is the patient likely to suffer a temporary impairment of mental, physical, or functional capacity due to alcohol, drugs, infections, or medical treatment?

—Does the patient have good emotional control or has he signs of antisocial behavior or an emotional disturbance making it unsafe for him to drive?

The Committee said that the physician is qualified by training to ascertain the physical, mental, emotional, or physiological impairments of an individual. He is in a good position to evaluate these impairments in relation to safe driving ability.

Frequently, it may be necessary for a physician, recognizing his responsibility for the safety of his patient and the public, to caution the patient against driving for a certain period of time or even permanently.

## *"Man Proposes; God Disposes" . . . PLAUTUS*

Married people have a greater chance of survival than single people.

This fact is revealed in a recent issue of Parke, Davis & Company's publication for the medical profession, *PATTERNS OF DISEASE*.

In 1957, the death rate for single men was about 75% higher than that for married men; for single women it was about 50% higher than that for married women, according to the publication.

*continued on page 272*



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Leading authorities always have recognized the value of brewer's yeast, but the necessity of giving a patient 30 to 40 large tablets a day has limited the usefulness of this valuable vitamin source. Now—*one* teaspoonful of NABCON a day will give the same results—results often significantly superior to synthetic B complex mixture.

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## THROUGH THE MICROSCOPE

*continued from page 270*

Tuberculosis, influenza and pneumonia rank among the leading death risks facing single people in greater proportion than married ones, PATTERNS reveals. For instance, tuberculosis killed four single men to every married man and two single women to every married one. There were more than three times as many deaths from influenza and pneumonia among single men as married men and twice the number among single women as their married sisters.

Other causes of death approximately twice as prevalent among single men as married men are peptic ulcer, cirrhosis of the liver, motor vehicle and other accidents, and suicide, according to PATTERNS.

Homicide, too, exacts a higher toll among the unattached. Compared to married men, the homicide death rate was nearly six times greater among the divorced, four times for widowers and almost double for single men! Among women, the rate is three times greater among the divorced than the married and almost three times greater among the widowed, although the rate for spinsters is only half that of wives.

*Medicine — Law — Ministry — Journalism*

High school editors, viewing their elders' professions believe that medicine offers the highest prestige, interest and usefulness to society, that law will pay best, and that the ministry is most conducive to a good family life. They rank journalism second only to medicine in interest, and place it midway among the professions in usefulness to society.

These were some of the results of a survey conducted by Columbia University's Graduate School of Journalism among more than a thousand students working on high school publications. Despite their participation in journalistic activities, the majority thought journalism offered low pay, difficult advancement, and inferior prestige and family life.

The practice of law, for example, was voted highest in material rewards, but ranked sixth among nine professions in usefulness to society. Teaching was voted lowest in prestige and financial prospects, but second only to medicine in usefulness. Bankers and business men were seen as engaged in the least useful and least interesting professions.

The findings were obtained from questionnaires circulated to 1,089 delegates to the 1958 meeting of the Columbia Scholastic Press Association. About 150 of the delegates also were interviewed by graduate journalism students under the direction of Samuel Lubell, who heads the School's Public Opinion Reporting Workshop. The survey was con-

*continued on page 274*

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Under the system which produces our American doctors, you can ask for and get the services of one of the most highly-trained men in the world. You can be sure of his ability — protected by extremely thorough courses of training and by standards for the profession set by law.

Your doctor, specialist or surgeon has spent nearly half his expected lifetime preparing for the medical profession. He has directed his efforts toward medicine alone — through a maze of preparation.

There's no short cut to becoming a physician. College, medical school, and internship — plus further study if he specializes — tremendous amounts of time and money must be spent before the State of Rhode Island finally grants his license.

More, today's doctor is a combination of skilled physician plus a human being who has learned how to apply his skills to caring for other human beings.

Today, under the care of your physician, you can be sure you're receiving medical and surgical care more advanced and complete than ever before.

It is the aim of Physicians Service to make that care available with increasing benefits to all the people of Rhode Island who ask for it.

*Better Health Care for More People Through*

# *Physicians Service*



## THROUGH THE MICROSCOPE

*continued from page 272*

ducted with the co-operation of Doctor Joseph Murphy, director of the Columbia Scholastic Press Association.

*Medical Research Stymied by State Laws*

The hodgepodge of laws and regulations now governing medical research obstructs and imperils progress in the life sciences, according to Doctor Lester R. Dragstedt, president of the National Society for Medical Research and professor of surgery at the University of Chicago School of Medicine. To bring order into this chaotic situation, the Society, in conjunction with the University of Chicago has called the first National Conference on the Legal Environment of Medical Science. The meeting will be held May 27, 28, on the University of Chicago campus.

Because in thirty-nine states you can will your automobile, your house, or your bank account, but cannot bequeath your cornea to an eye bank, or your own body to a medical school for research, scientists are facing a critical lack of materials for research in anatomy, pathology and organ transplants. "In an era when physical science knows no limits," Doctor Dragstedt stated, "biology and medical advances are thwarted by jerry-built laws which were mainly enacted before the new medical possibilities appeared on the horizon."

Physicians, scientists, and lawyers also are confused over legal rights and responsibilities toward human beings serving in trials of new medical treatments. Practical problems such as access to cadavers and obtaining animals for humane use in laboratories, according to Doctor Dragstedt, has stimulated the Society, whose membership includes all the accredited medical schools and most medical research associations, to issue a call for clarification of standards.

*\$505,000 to Test Antibiotic "Beers"*

Surgeon General Leroy E. Burney of the Public Health Service has announced the award of a \$505,000 contract to The Upjohn Company, Kalamazoo, Michigan, to develop, test, and manufacture antibiotic and related drugs in the search for compounds effective in the treatment of cancer.

This is the first such contract awarded by the Service's Cancer Chemotherapy National Service Center at the National Cancer Institute under a new patent policy of the Department of Health, Education, and Welfare.

Under the agreement, The Upjohn Company will test antibiotic "beers" for anticancer activity. They will seek to identify and isolate specific agents in the "beers" that show promise for the treatment of cancer. If this work yields potentially useful drugs, Upjohn will proceed with the necessary additional

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research to determine whether such agents are safe for use in cancer patients.

Safe, promising drugs will be evaluated in clinical trials under the direction of the Cancer Chemotherapy National Service Center. If the results of these trials indicate that one or more of the drugs are of real value in treating cancer, the Company is obligated to undertake production of them.

Approximately 100 research contracts, many with the Nation's leading pharmaceutical firms, are now administered by the Cancer Chemotherapy National Service Center.

#### *Sixty-five-Year Old Lead Nation in Insurance Coverage*

The proportion of persons in the sixty-five-and-over age group who have individual health insurance policies is greater than the national average of all age groups for such protection, reports the Health Insurance Institute.

A nation-wide consumer survey of health insurance, conducted by the National Analysts of Philadelphia and just published by the Institute, showed that 23% of the population sixty-five and over, or 3.5 million persons, were protected against the costs of accident and sickness by individual health care policies. This percentage does not include those persons covered only under group health insurance programs.

When the survey data were collected in November 1957, it was found that some 35% of the persons sixty-five and over had individual or group health insurance coverage. By the end of 1958, the Institute estimated that more than 40% of senior citizens were protected by health insurance.

In the individual health policy field, the 23% coverage figure for the sixty-five-and-over age bracket surpassed the 22% figure for the over-all population of the U.S. Some 38 million Americans were covered by individual policies, the Institute said.

Still further improvement in the number of senior citizens who have health insurance is pre-saged by the growth and development of new programs aimed specifically at the sixty-five-and-over field, according to a statement by the Institute.

In less than eighteen months, these insurance company programs limited to persons sixty-five and over have been introduced into more than one third of the nation's forty-nine states. Similar and more numerous plans almost certainly will be spread to other states in the near future, predicts the Institute.

**Check May 12 and 13 . . .**

**Annual Meeting of the  
Rhode Island Medical Society**

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PROGRAM OF THE 148th ANNUAL MEETING  
RHODE ISLAND MEDICAL SOCIETY

*May 12 and 13, 1959*

*At the Rhode Island Medical Society Library*

TUESDAY, MAY 12

8:30 P.M. "THE VALUE AND LIMITATIONS OF LIVER FUNCTION TESTS"

FRANKLIN M. HANGER, M.D.

(Professor of Medicine, Columbia University; Attending Physician,  
Presbyterian Hospital, New York, New York)

9:00 P.M. "CHAPIN AND MODERN EPIDEMIOLOGY"

(Charles V. Chapin Oration)

JOHN R. PAUL, M.D.

(Member of the Department of Internal Medicine, Yale University;  
Professor of Preventive Medicine at Yale University)

WEDNESDAY, MAY 13

10:30 P.M. "THE RHODE ISLAND WOMEN'S STATE CYTOLOGY PROGRAM  
PROGRESS REPORT"

YO SEUP SONG, M.D.

(Associate Director, Rhode Island State Cytology Program;  
Assistant Pathologist, Rhode Island Hospital)

11:00 A.M. "MEDICAL ASPECTS OF IATROGENIC DISEASE"

ANTHONY CAPUTI, M.D.

(Cardiologist and Senior Physician, Department of Medicine,  
Newport Hospital)

JANIS GAILITIS, M.D.

(Associate Physician, Department of Medicine, Newport Hospital)

11:30 A.M.- PANEL ON DEAFNESS

12:30 P.M.

RUDOLPH PEARSON, M.D.

(Chief of the Department of Otolaryngology, Rhode Island Hospital)

EDWIN B. GAMMELL, M.D.

(Surgeon, Department of Otolaryngology, Rhode Island Hospital;  
Chief, Department of Otolaryngology, Memorial Hospital)

DONALD K. LEWIS, M.D.

(Associate Surgeon at Massachusetts Eye and Ear Infirmary and Massa-  
chusetts General Hospital; Associate Director of Winthrop Foundation at  
Massachusetts Eye and Ear Infirmary)

2:00 P.M. "VIRAL INFECTIONS OF THE RESPIRATORY TRACT"

HARRY M. ROSE, M.D.

(John E. Borne Professor of Medical and Surgical Research; Chairman,  
Department of Microbiology, College of Physicians and Surgeons, Colum-  
bia University; Attending Microbiologist; Associate Attending Physician,  
Columbia-Presbyterian Medical Center)

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ep among *all* persons.

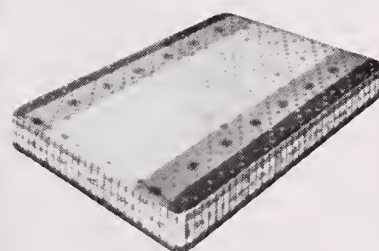
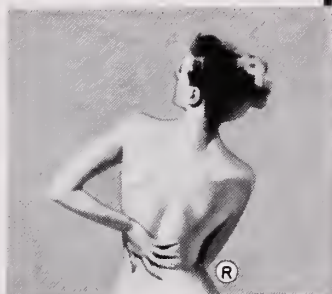
a "corrective device" it serves those chronically afflicted with  
ver back syndromes. As a preventive measure Sealy Posturepedic  
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for mattress and matching foundation)

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## PROGRAM OF THE 148th ANNUAL MEETING

*concluded from page 276*

- 2:30 P.M. "INDICATIONS AND RESULTS OF INFERIOR VENA CAVAL LIGATION IN THE TREATMENT OF THROMBOEMBOLIC DISEASE"

JOHN B. BLALOCK, M.D.

(Department of Surgery, Ochsner Clinic and Ochsner Foundation Hospital; Instructor in Surgery, School of Medicine, Tulane University)

- 3:15 P.M. "VISUAL PROBLEMS IN ROENTGEN DIAGNOSIS"

WILLIAM J. TUDDENHAM, M.D.

(Assistant Professor, School of Medicine and Graduate School of Medicine, University of Pennsylvania)

- 3:45 P.M. INTERMISSION

- 4:15 P.M. "BRONCHOGENIC CARCINOMA: PREDISPOSING CAUSES"

ALTON OCHSNER, M.D.

(Director of Surgery, Ochsner Clinic and Ochsner Foundation Hospital; Professor of Clinical Surgery, Tulane University School of Medicine, Louisiana)

- 4:45 P.M. "OUR ALLIES, THE HOSPITALS AND BLUE PLANS; ASSETS OR LIABILITIES?"

(Presidential Address)

FRANCIS B. SARGENT, M.D.

(President of the Rhode Island Medical Society)

- 8:30 P.M. DINNER MEETING, Sheraton-Biltmore Hotel  
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F. J. L. BLASINGAME, M.D.

(Executive Vice-President, American Medical Association)



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## BOOK REVIEWS

*ORTHOPEDIC DISEASES.* Physiology—Pathology—Radiology by Ernest Aegerter, M.D. and John A. Kirkpatrick, Jr., M.D. W. B. Saunders Co., Phil., 1958. \$12.50

The authors (a pathologist and a radiologist) have attempted to present to the busy physician a primer of orthopedic diseases. Their attempt is quite successful. They look at bone disease from the standpoint of its altered morphology and physiology, yet interpret these in terms of symptomatology and roentgenography. They present little original material, but have made available to the physician in a well organized volume the pertinent literature of their subject. "It is intended for the clinician who wants to increase his diagnostic efficiency, for the radiologist who is perplexed by the meaning of an overwhelming array of radiographic nuances, for the pathologist who is distraught by his inability to interpret what he sees through his microscope, for the young specialist who wants to pass his board examinations, and for the medical student who must acquire a certain amount of knowledge of orthopedic diseases in order to graduate."

The book is well illustrated. The type is large and easily read. The authors are to be congratulated for this fine book.

STANLEY D. SIMON, M.D.

*CALLANDER'S SURGICAL ANATOMY* by Barry J. Anson, M.A., Ph.D. (Med.Sc.) and Walter G. Maddock, M.S., M.D., F.A.C.S. W. B. Saunders Co., Phil., 1958. 4th ed. \$21.00

The new fourth edition of this work, a recognized standard in surgical anatomies, closely follows the format of previous editions. The text has been edited by Doctors Barry Anson and Walter Maddock, chairmen of the Departments of Anatomy and Surgery at Northwestern University Medical School. This collaboration between anatomist and surgeon is well mirrored in the finished text. The over-all arrangement is familiar to those who have used prior editions. The sections on surgical considerations have been brought into line with current thought. The choice of illustrations is excellent and, in addition to a fine and improved text of anatomy, the book also contains an equally good atlas of surgical techniques.

The only criticism that can be offered is that the binding of the review copy seemed somewhat inadequate. It is doubtful if it will withstand the constant use that the 1157 pages contained within will surely be subjected to over the years.

This volume is a classic, and will serve faithfully any of the profession who chooses it to guide him through his preparation for and practice of surgery.

BANICE M. WEBBER, M.D.

*A DOCTOR'S MARITAL GUIDE FOR PATIENTS* by Bernard R. Greenblat, B.S., M.D. The Budlong Press, Chic., 1957. "Regular" Edition; "Rhythm" Edition. \$1.50. Lower price in quantity.

In pocket-size handbook form, this easy-reading outline in three parts with appendix, gives (1) *Some Facts of Life*, stating sound, orienting considerations regarding sex and marital life, reproductive anatomy and endocrinology; (2) *The Sexual Act*, dealing with its many facets (a chart diagramming coital postures is available); and (3) *Conception and Pregnancy*. The appendix outlines reasons for conception control. The *Regular* edition discusses contraception; the *Rhythm* edition outlines approved use of this method. A glossary is appended.

The guide will be found invaluable to doctors dealing with and patients having maladjustment in marriage. Also, it can be a timesaver for the doctor, and a ready source of fact and orientation for the patient, in infertility work. And, as stated in the foreword by Cornelius Benkenkamp, M.D. "None of us, for that matter, is so sophisticated or mature that this contribution cannot be of some value." Also, "I am gratified to say that the author has stressed the simplicities as well as recommended definitive care."

Containing many generalities, some of which the doctor might wish to qualify, it is considered, sound information for the layman—and, in good taste. Copies are available to physicians only.

GEORGE W. DAVIS, M.D.

*DIFFICULT DIAGNOSIS.* A Guide to the Interpretation of Obscure Illness by H. J. Roberts, M.D. W. B. Saunders Co., Phil., 1958. \$19.00

This is a splendid work to be kept close at hand for easy reference. Panoramic in scope, embracing

continued on page 282



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## BOOK REVIEWS

*continued from page 280*

the full range of diagnostic clues based on all points of history, physical findings and laboratory data as well as salient differential diagnostic points, it more than fulfills the promise held within its subtitle of: *A Guide to the Interpretation of Obscure Illness.*

Dr. Roberts has divided his opus into two main categories: *Part I*, or, Groupings of Related Diseases Frequently Producing Puzzling Illness and, *Part II*, A Classification and Analysis of Useful Diagnostic Procedures.

*Part I* contains seventeen groups as follows: Endocrinopathies, Metabolic Disorders, Hepatic Disease and Jaundice, Fever and Infection of Obscure Origin (general considerations), Infections (specific), Hematologic Disease, Non-infectious Granulomata, Vascular Diseases, Diseases of the Heart and Great Vessels, Dyscollagenoses, Neoplastic Diseases, Disorders of the Nervous System, Iatrogenic Illness, Miscellaneous Entities (including heredofamilial diseases), Obscure Postoperative Complications, Medical-Surgical Diagnostic Problems relating to Obscure Abdominal Pain, Gastro-intestinal Hemorrhage and Intestinal Obstruction, and, lastly, Cutaneous Medicine, the latter accompanied by an atlas of systemic dermatoses.

*Part II* contains sixteen sections: Hematologic

Studies, Blood Chemistries, Renal Function Tests, Liver Function Tests and other related studies, Studies of Endocrine Function, Bacteriologic and Immunologic Studies, Studies of Gastrointestinal Function, Studies of the Central Nervous System, Studies of Cardiovascular-Pulmonary Function, Exfoliative Cytology, Biopsies in Clinical Medicine, Supplementary X-ray and Photographic Procedures, Studies of the Eyes in Systematic Disorders, Therapeutic-Diagnostic Tests, Withdrawal Tests, and Provocative Tests.

In addition to this rather complete review of internal medicine, each of the two main parts of the book contains a list of bibliographical references. Lastly, there are appended an index of signs, symptoms, and laboratory manifestations and a general index. Throughout the book itself there are numerous cross references to related subjects treated elsewhere within its pages.

Dr. Roberts has accomplished a monumental work, illustrating the complexities of the field of diagnostic medicine, and, at the same time, satisfying full well one of the hopes set forth in his introduction, that "this presentation will prove to be both timely and helpful to the interested reader, who is often limited in time, immediate useful references and methods of approach in dealing with these not too uncommon diagnostic problems."

JEANNETTE E. VIDAL, M.D.

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**DRUGS.** Their Nature, Action and Use by Harry Beckman. W. B. Saunders Co., Phil., 1958. \$15.00

This very readable text has been written largely for the undergraduate medical student, but will be found to be of valuable interest to the practitioner of medicine because of the skillfully concise discussions of drugs and their action.

It is a well-written paper on whether certain chemical configurations do confer specific pharmacologic attributes upon a compound in which they are incorporated. Many illustrations are given in this text showing that there is no true predictability of pharmacologic action with chemical structure.

It is popular nowadays to scoff at carminatives; nevertheless, clinical faith in them has persisted. The reviewer found a delightful two-page discussion of this common problem.

The text is recommended for many up-to-date presentations of the proper use of drugs as given in a very easy assimilated form.

ABRAHAM SALTZMAN, M.D.

**EMERGENCY WAR SURGERY.** U.S. Armed Forces Issue of NATO Handbook Prepared for Use by the Medical Services of NATO Nations. United States Department of Defense, Wash., 1958. \$2.25

EMERGENCY WAR SURGERY was developed by the Military Medical Services of France, the United Kingdom, and the United States, with assistance by observers from other NATO nations. The international character is consistent with the fact that small as well as large wars are being fought by groups of nations.

The bulk of the material as might be expected consists of basic and long established fundamentals of civilian and military medicine and surgery. Features distinguishing this manual from those previously published are three in number.

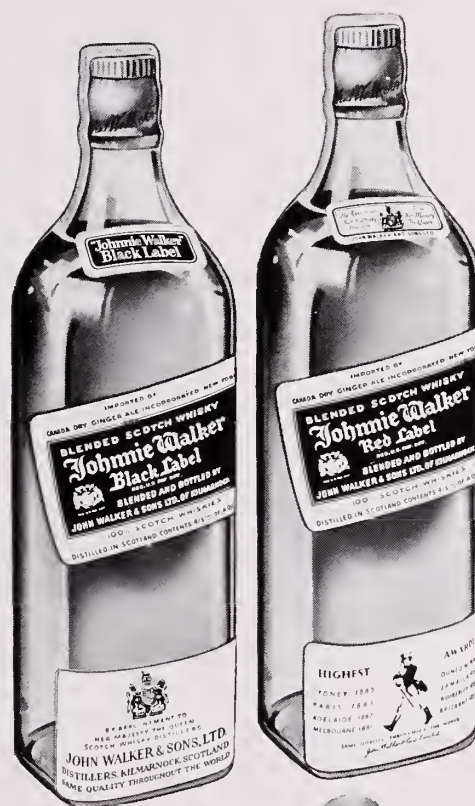
There is a most important section on surgical physiology titled *Response of the Body to Wounding* in which may be found sub-sections on shock and resuscitation, metabolic disturbances after trauma, and infection.

The need for a section on radiation injury is obvious, yet it is interesting to note that this incalculably important aspect of wars to come is dealt with in a chapter of less than seven pages. This is reasonable now that the initial aura of mystery concerning nuclear devices has been dispelled to reveal that their radiation is basically similar to that long used by the scientific world, differing only in dose. Furthermore, there is no specific therapy known which will reverse pathologic changes of tissues exposed to noxious doses of radiation.

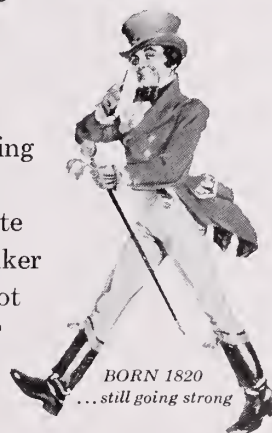
Lastly, there is a paragraph or two appended to

*continued on next page*

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each section labeled *Mass Casualties*. While mass casualties have always been a part of warfare, the connotation of the word "mass" has abruptly changed. The essence of the change is that the group of forlorn hope created by triage will be staggeringly out of proportion to the salvageable and self-sustaining casualties. Literally myriads of individuals will be consigned to die because of the nature of the injury and or the lack of medical attention available. It is more than hinted that there may well be nothing available to this group, and this includes palliative morphine.

Although the possibilities are grim, an attitude of resignation is not acceptable. The NATO handbook should become a part of the library of every hospital, civil defense unit, and physician, without exception. It is devoutly to be wished that it never be opened for the primarily intended purpose. It may be very useful in local minor disasters such as fires and industrial and transportation accidents.

The NATO handbook of 411 pages within a semi-hard cover may be purchased from the Superintendent of Documents, United States Government Printing Office, Washington 25, D.C., at a cost of \$2.25.

J. E. CARUOLO, M.D.

*GYNECOLOGIC AND OBSTETRIC PATHOLOGY* With Clinical and Endocrine Relations by Emil Novak, M.D. and Edmund R. Novak, M.D. W. B. Saunders Co., Phil. 1958. Fourth edition. \$14.00

This is the fourth edition of one of the most classic texts dealing with obstetrical and gynecological pathology. It is a book of 650 pages containing 683 illustrations, 25 of which are in color. As a desk reference, it is an absolute *must* for medical students, residents in training, practicing obstetricians, gynecologists and pathologists.

It is the last time that this text will bear the name of its senior and original author. Dr. Emil Novak, late assistant professor emeritus of gynecology at Johns Hopkins Medical School died on February 3, 1957. He was a gentle man of great integrity, vast knowledge and extreme dignity. He possessed those superior qualities of leadership which are inherent in all great teachers, and among his many honors he was past president of the American Gynecological Society, editor of the gynecological section of the *OBSTETRICAL AND GYNECOLOGICAL SURVEY*, and director of the Johns Hopkins Ovarian Tumor Registry. Although in ill health for many months, he continued his writings and contributed greatly toward the context of this fourth edition.

Future editions of this book will bear the names of Dr. Edmund R. Novak, the senior author's son,

and Dr. Donald Woodruff, who is director of Gynecological Pathology at Johns Hopkins.

This is a unique pathology text because it contains refreshing physiological, embryological, endocrinological and clinical relations. Because of these added features it is not heavy reading but, rather, entertaining, provocative and stimulating. There are exhaustive and up-to-date references to the literature at the end of each major chapter.

The fourth edition contains several major changes. A new 33-page chapter is devoted to exfoliative cytology, the section dealing with placental abnormalities, implantation and placentation has been completely revamped in accordance with newer concepts, and the chapter dealing with breast pathology has been discontinued. The reason for this latter change is because of space limitations and the fact that several excellent texts on breast disease are available.

In summary, the reviewer believes this text to be pre-eminent in its field, one which will be ever new, and will stand always as a monument to the greatness of one of America's most outstanding gynecologists—Dr. Emil Novak.

HENRY C. McDUFF, JR., M.D.

*THE ANATOMY OF THE NERVOUS SYSTEM; ITS DEVELOPMENT AND FUNCTION* by Stephen Walter Ranson, M.D., Ph.D., and Sam Lillard Clark, M.D., Ph.D. W. B. Saunders Company, Phil. 1959. 10th ed. \$9.50

This preferred textbook of Neuroanatomy has been profitably revised and is published as the tenth edition. Function is increasingly related to structure which gives continuity in understanding the complex but fascinating nervous system of the human body. The general approach to the subject matter remains faithful to the one Ranson conceived which the passage of time continues to indicate was a good one.

Browsing through the book, the reviewer happened upon facts here and there which had not been retained — or were never noticed — and this in spite of almost weekly use of this textbook. Man has acquired much knowledge of the central nervous system but questions to which there are no answers are still myriad. It was amusing to observe that a very ancient part of the nervous system, namely the Rhinencephalon, is essentially unchanged. After all, this portion of the brain would not be very functional in space.

The style of writing continues to be clear and pleasant. The book's format and illustrations create interest. The reviewer might wish that the anatomy of the arteries of the brain was more extensive and detailed. This book will continue to be a preferred text.

HAROLD W. WILLIAMS, M.D.

concluded on page 286

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Thiamine Mononitrate (B <sub>1</sub> ) . . . . .	5 mg.
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## BOOK REVIEWS

*concluded from page 284*

*WHAT WE DO KNOW ABOUT HEART ATTACKS* by John W. Gofman, M.D. G. P. Putnam's Sons, N.Y. 1958. \$3.50

"What We Do Know About Heart Attacks" is an unusual and an interesting book more for the layman than for the physician. However, I derived a great deal of pleasure from reading it.

In this day and age when heart attacks account for approximately three times as many deaths as all forms of cancer combined, it is terrifying to know that all too frequently individuals early in life and at the height of their careers are struck down "before the ink has dried on a large life insurance policy just issued them."

The author is a professor of medical physics of the University of California. He is uncanny in his ability to isolate statistics concerning behavior patterns and hereditary and environmental factors weaving their influences upon the lipoproteins of the blood and hypertension. These two latter entities are then used in a formula to compute the Atherogenic Index which correlates very nicely previous heart attacks and the risk of future ones.

I enjoyed thoroughly the book's simplicity of

## RHODE ISLAND MEDICAL JOURNAL

language and its ease of understanding and feel that the reader will carry away a thorough knowledge of the subject.

LESTER M. FRIEDMAN, M.D.

*PRACTICAL DERMATOLOGY* by George M. Lewis, M.D. W. B. Saunders Company, Phil. 1959. 2nd ed. \$8.00

A second edition is a visible demonstration of success. The book, with its concise text, free from cumbersome references, fulfills nicely the purpose of introducing dermatology to the student and to the general practitioner. The addition of a chapter on basic science is highly commendable. The 555 black and white illustrations are excellent; their number is large for a 363-page text.

The prohibitive cost of color-illustrations is a well-known handicap for a book on dermatology. An illustration in color of vitiligo or of alopecia areata would be a wasteful expense. For other skin disorders as, for example, for Kaposi's sarcoma, they are essential. "Venereal warts" for "acuminated condylomata" must be a lapsus calami.

I recommend the book highly.

F. RONCHESI, M.D.



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symptom complex

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salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as  
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1. Based on estimate by Van Volkenburgh, V. A., and Frost,  
W. H.: Am. J. Hygiene 71:122 (Jan.) 1933



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References: 1. Carozzi, M.: Ant. Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: Ant. Med. & Clin. Therapy 5:52 (Jan.) 1958. 3. Welch, E.: Deutsche med. Wchnschr. 81:661 (April) 1956. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 1958. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: Ant. Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L., Sedlis, A. J., Barnford, J., and Bradley, W.: Ant. Med. & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.





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## Medical Journal

Volume XLII, No. 5

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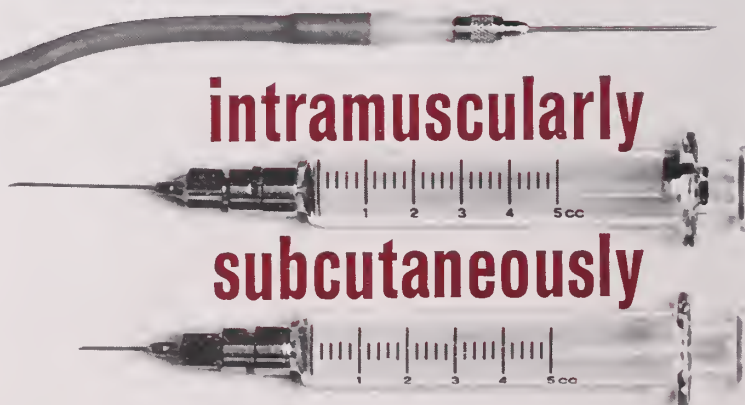
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Shiga dysentery <sup>1</sup>	14	14		
Septicemia <sup>1</sup>	10	6	2	2
Septicemia <sup>1,4</sup>	5	5		
Septicemia <sup>1,4</sup>	4	3		1**
Mountain fever <sup>1,4</sup>	2	2		
Septicemia with ulcers <sup>3</sup>	1	1		
Septicemia <sup>3</sup>	1			1
Septicemia <sup>4</sup>	1	1		
ALL	70	64	2	4

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**REFERENCES**—(1) Ross, S.; Puig, J. R., & Zaremba, E. A., in Welch, H., & Marti-Ibañez, F.: *Antibiotics Annual 1957-1958*, New York, Medical Encyclopedia, Inc., 1958, p. 803. (2) Glazko, A. J., et al.: *ibid.*, p. 792. (3) Payne, H. M., & Hackney, R. L., Jr., in Welch, H., & Marti-Ibañez, F.: *Antibiotics Annual 1957-1958*, New York, Medical Encyclopedia, Inc., 1958, p. 821. (4) McCrumb, E. R., Jr.; Snyder, M. J., & Hicken, W. J.: *ibid.*, p. 837.

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1. Kety, S. S.: A medical regimen for benign rectal disorders, *GP* 10:73, Nov., 1954.

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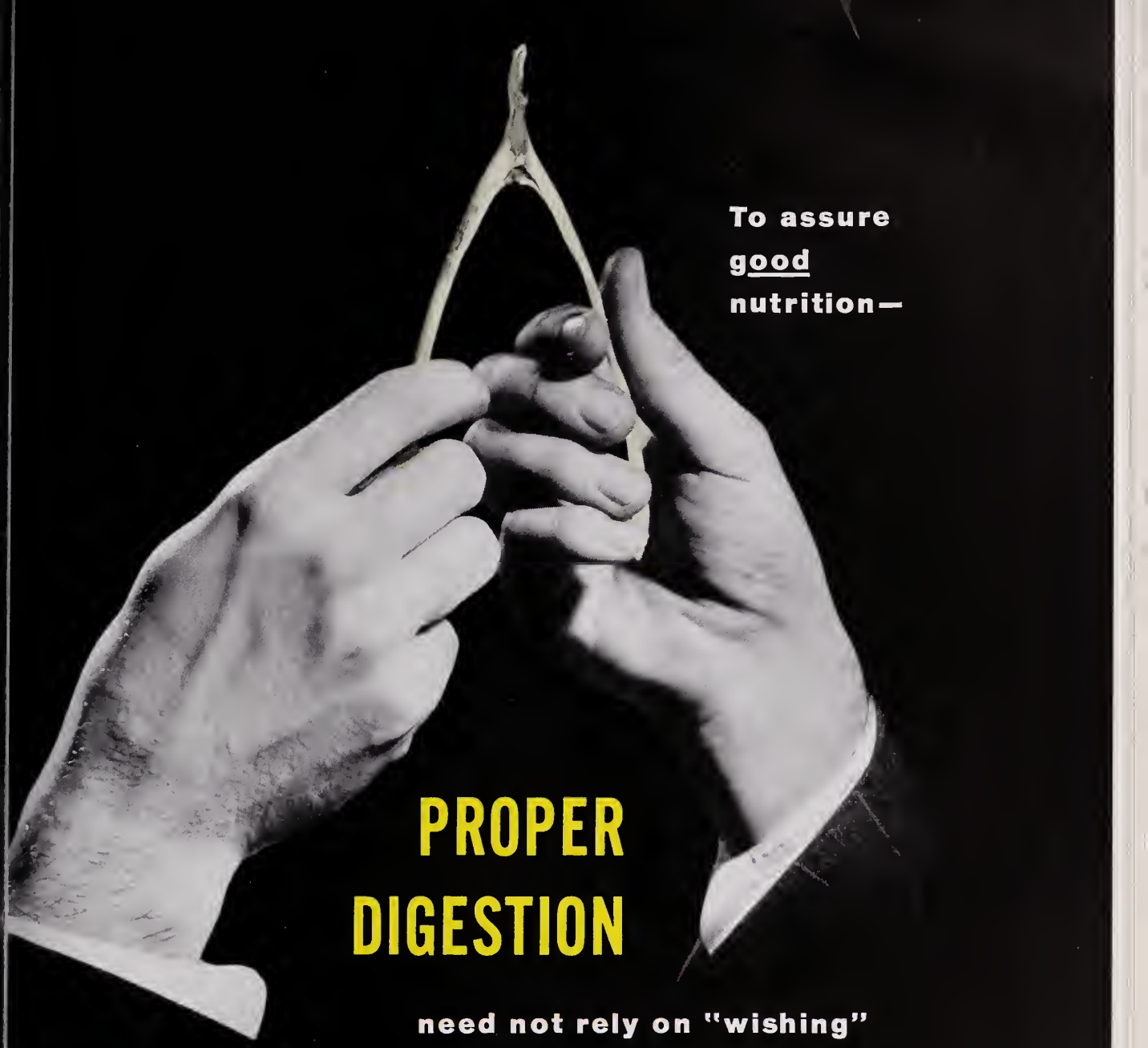
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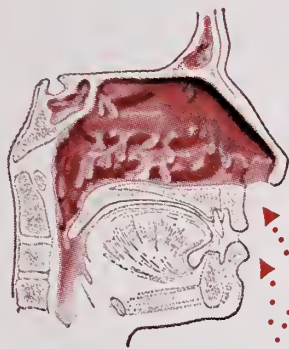
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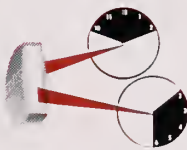
*References:* 1. Sheldon, J. M.: Postgrad. Med. 14:165 (Dec.) 1953. 2. Hubbard, T. F. and Berger, A. J.: Annals Allergy p. 350 (May-June) 1950. 3. Kline, B. S.: J. Allergy 19:19 (Jan.) 1948. 4. Goodman, L. S. and Gilman, A.: Pharmacol. Basis Ther., Macmillan, New York, 1956, p. 532. 5. Tabricant, N. D.: I.F.N.T. Monthly 37:160 (July) 1958. 6. Lhotka, F. M.: Illinois M.J. 112:259 (Dec.) 1957. 7. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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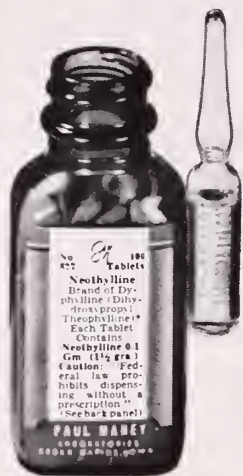
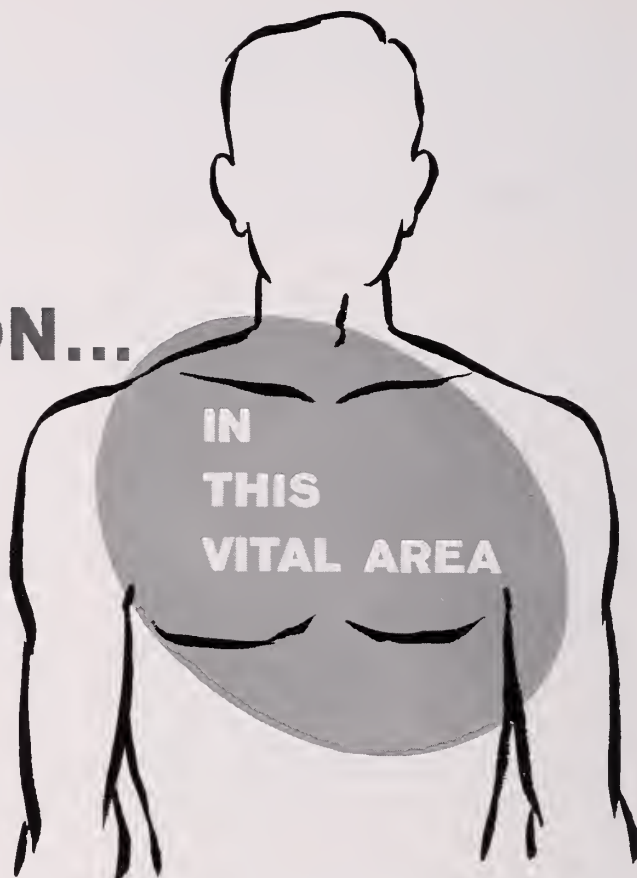
(1) Ernst, E. M., and Snyder, A. M.: *Pennsylvania M. J.* 61:355, 1958.

(2) Preisig, R., and Landman, M. E.: *Am. Pract. & Digest Treat.* 9:740, 1958.

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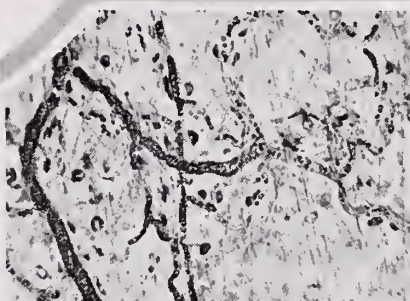
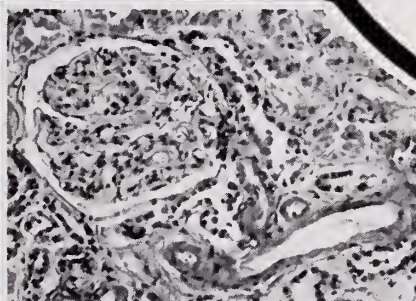
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LITERATURE AVAILABLE ON REQUEST.

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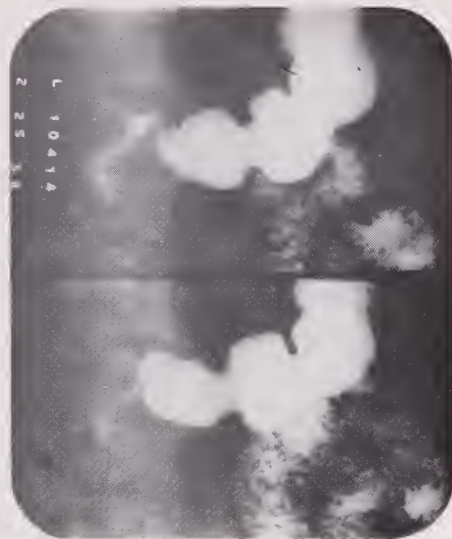


-and control its G.I. sequelae



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Intermittent crises of severe pain over 2 year period; hospital management with Sippy regimen provided relief of symptoms; however, symptoms recurred after each sojourn.



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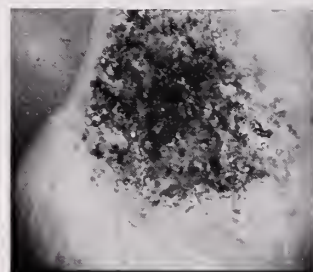
**References:** 1. Shelmire, J.B., Jr.: Monographs on Therapy 3:164 (Nov.) 1958. • 2. Nix, T.E., Jr., and Derbes, V.J.: Monographs on Therapy 3:123 (Nov.) 1958. • 3. Robinson, R.C.V.: Bull. School of Med., U. Maryland 43:54 (July) 1958. • 4. Sternberg, T.H.: Newcomer, V.D., and Reisner, R.M.: Monographs on Therapy 3:115 (Nov.) 1958. • 5. Clark, R.F., and Hallett, J.J.: Monographs on Therapy, 3:153 (Nov.) 1958. • 6. Smith J.G., Jr.; Zawisza, R.J., and Blank, H.: Monographs on Therapy, 3:111 (Nov.) 1958. • 7. Monographs on Therapy, 3:137 (Nov.) 1958. • 8. Howell, C.M., Jr.: North Carolina M.J. 19:449 (Oct.) 1958. • 9. Bereston, E.S.: South. M.J. 50:547 (April) 1957. And whatever the topical corticoid need, a suitable Squibb formulation is available — Kenalog-S Lotion — 7½ cc. plastic squeeze bottles. Each cc. supplies 1.0 mg. (0.1%) triamcinolone acetonide, 2.5 mg. neomycin base and 0.25 mg. gramicidin. Kenalog Cream, 0.1% — 5 Gm. and 15 Gm. tubes. Kenalog Lotion, 0.1% — 15 cc. plastic squeeze bottles. Kenalog Ointment, 0.1% — 5 Gm. and 15 Gm. tubes.



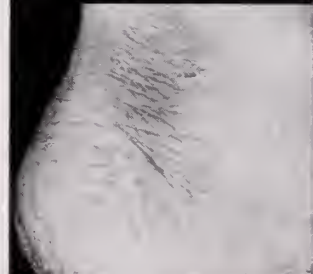
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Levin, Samuel J.: Management of the Acute Asthmatic Attack in Childhood. *Ped. Clin. of N. A.* 1:975, (November) 1954.

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Naterman, H. L.: Epinephrine Base Suspended in Water with Thioglycollate. *J. Allergy* 24:60, (Jan.-Feb.) 1953.

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Unger, A. H., and Unger, L.: Prolonged Epinephrine Action. A Report on Use of an Epinephrine Suspension. *Ann. Allergy* 10:128, (Mar.-Apr.) 1952.

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Jenkins, C. M.: A Clinical Study of "Sus-Phrine", an Aqueous Epinephrine Suspension for Sustained Action. *J. Nat. M. A.* 45:120. (Mar.) 1953.

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**SEARLE**

## THE TREATMENT OF CORONARY HEART DISEASE\*

CLAUDE S. BECK, M.D.

The Author, *Claude S. Beck, M.D.* of Cleveland, Ohio,  
Professor of Cardiovascular Surgery, Western Reserve  
University, Cleveland, Ohio.

### Introduction

UNTIL THE TIME arrives when coronary artery disease can be prevented, the methods of treatment are important and deserve critical analysis. Can we define what we would like to accomplish in the treatment of this disease? The things that we would like to accomplish in treatment, *i.e.*, the desirables, may or may not be possible of accomplishment. We would like to prevent arterial disease. If this is not possible we would like to retard or stop its progress. If this cannot be done, we would like to open a coronary artery, clean out the debris and restore the lumen. We would like to restore destroyed muscle. If this cannot be done, we would like to prevent further destruction. We would like to cure anginal pain. We would like to reduce the danger of sudden death in hearts too good to die. If we knew what could be accomplished, then we could concentrate on the things that are possible. It is difficult to separate the possibilities from the impossibilities. An analysis of the disease will help to make this separation.

### Routines in Treatment

The medical treatment of coronary heart disease has been simplified to the status of therapeutic routines. After a routine becomes established, it automatically enters a sanctuary where it is free from critical analysis and attack. The author's operation as a form of treatment has earned a favorable place in science, but it occupies no such favored position as does a medical routine. Many medical cardiologists have denied the value of this operation. In so doing they deny the validity of the experimental method which William Harvey did so much to create 300 years ago. Both forms of treatment, medical and surgical, are to be subjected to critical

analysis, the same for one as for the other. In this way the value of each can be compared.

### Analysis of the Disease

To assess relative values of surgical operation and medical treatment it is necessary to separate the things that can be done from the things that can't be done. Then it will be possible to deal with the former and avoid the latter. To make this separation it is necessary to dissect the disease into its components. Then each component can be analyzed in pure form. As a single unit the disease is so complex that it can scarcely be understood.

The disease has two components. One is physiological and cannot be identified by the pathologist. The other is structural and is readily identified. One component is anginal pain and self electrocution. The other is disease in arteries and muscle, figs. 1 and 2.

### Pain and Self Electrocution

Both of these physiological manifestations of the disease are produced by localized anoxia in the heart muscle. They occur anywhere in the course of structural disease. They occur early when structural disease is minimal. They also occur late when structural disease is approaching the terminal stages. The patient with pain and fear of sudden death

*continued on next page*

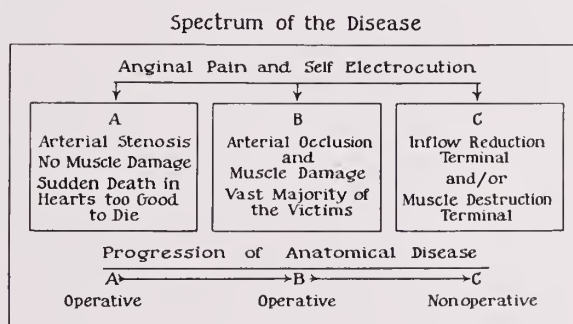


FIGURE 1

Anginal pain and fibrillating currents may occur anywhere in the course of the disease. These are the only aspects of the disease that can be treated. Structural disease moves from A to B to C. To relieve pain and to delay death until the disease arrives at C are the purposes of treatment.

\*The experimental work was supported by grants from the United States Public Health Service and the Cleveland Area Heart Society.

Presented at the Scientific Session of the Rhode Island Heart Association, at Providence, Rhode Island, April 8, 1959.

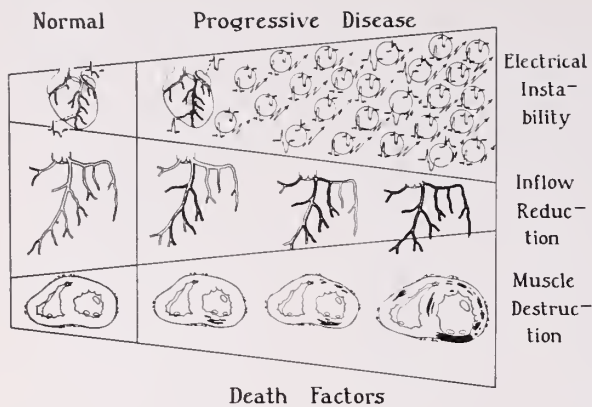


FIGURE 2

Three factors in the disease that kill. Arterial inflow reduction and death of muscle are the two structural forms of the disease. Severe inflow reduction can occur without an infarct. Structural disease in arteries or muscle cannot be reversed. Intercoronaries reduce the size of an infarct if they are present before a major artery is occluded. Fibrillating currents and anginal pain are produced by localized anoxia in the heart muscle. These physiological manifestations of the disease can be treated by creation of intercoronaries.

wants the facts concerning treatment. Which form of treatment provides the greatest relief of pain? Which protects life? The patient deserves to have the answers to these questions.

### Structural Disease

The physiological manifestations of pain and electrocuting currents are removed from this discussion of structural disease. With these exclusions life is safe and free of pain from an early beginning of disease in arteries and muscle until each of these reaches its terminal point when each can kill. Arterial disease kills by reducing arterial inflow to the point where there is not enough blood getting into the heart to support the heart beat. The normal coronary arteries are capable of carrying much more blood than the heart can use. An opening of 1.5 m.m. in diameter in one artery can allow enough blood to enter the heart to support the heart beat. Many years may be required for the disease to reduce inflow to this terminal level. This end-point can be reached without an infarct developing in the heart muscle. As arterial disease runs its course usually one artery after another becomes blocked off. One segment of muscle after another is destroyed. Finally, a stage is reached where there is not enough muscle to circulate the blood and the patient dies in failure. This type of death may be referred to as muscle-death. Total arterial inflow might be enough to support the heart beat. In summary, structural disease kills by inflow reduction, by muscle destruction or by a combination of both.

### Treatment of Structural Disease

Structural disease in arteries and muscle imposes severe limitations upon treatment. Probably nothing can be done to clean out the arteries after they are stenosed or blocked off. Little can be accomplished by addition of blood to the heart from outside sources. The heart resists the entrance of outside blood. Nothing can be done to restore destroyed muscle. Intercoronaries, if present before a major artery is blocked off, will reduce muscle destruction if and when an artery becomes occluded later on. This is perhaps the only possibility in treatment of structural disease and is effective only in a prophylactic way. The presence of severe structural disease in arteries and muscle and the conviction that nothing can be done to restore these conditions to normal is responsible for considerable negative reaction toward any kind of treatment. This negative attitude should not be applied to the physiological manifestations of pain and fibrillating currents because these may be based upon mild and early structural changes in the heart when they are readily amenable to effective treatment.

### Treatment of Physiological Manifestations

Pain and fibrillating currents are due to localized ischaemia in the heart muscle. They are not due to inadequacy of total artery inflow. They are due to an uneven or checkerboard distribution of inflow. Treatment is based upon the creation of intercoronaries and these ration the available blood so that every part of the heart muscle receives some blood. Intercoronaries are produced by surgical operation. This analysis creates a breakthrough in understanding the disease because physiology *versus* structure can be treated.

### Localized Anoxia in the Heart Versus Generalized Anoxia

A uniformly and deeply cyanosed heart is electrically stable and does not fibrillate. Examples of this are children born with cyanotic heart conditions, patients with acquired cyanosis from pulmonary disease such as emphysema and pulmonary fibrosis and patients with cyanotic valvular disease of the heart. Generalized cyanosis, be it mild or severe, does not produce anginal pain and does not disturb electrical equilibrium in the heart. Generalized and deep cyanosis was produced in 77 dogs in my laboratory and none of them fibrillated. Localized anoxia in the heart produces anginal pain, cardiac arrhythmias with ventricular complexes and ventricular fibrillation. These electrical charges can be produced in the laboratory by ligating a coronary artery in a pink heart or by perfusing well-oxygenated blood into a coronary artery of a cyanosed heart. Such electrical charges produced in areas of muscle receiving different amounts of oxy-



generated blood kill the child with an anomalous coronary artery. They also kill many of the victims of coronary disease.

The characteristics of ventricular fibrillation produced by currents generated within the heart are worthy of note. Fibrillation has the stature of an important lethal disease but the pathologist never finds it in the dead body. It's a mystery without anatomical identity and leaves no trace when it kills. It embarrasses the medical intellect by killing when it shouldn't, when anatomical disease is mild and when life is considered safe. It kills a good heart as readily as it kills a severely damaged heart, an infant as readily as an adult. It has no respect for sex but it kills more men than women. It kills with or without warning, with or without anginal pain. It kills millions of people, it's our modern scourge. Society recognizes it, lives with it and does not fight it. Medical circles have a strange complacency towards it. The idea of preventing ventricular fibrillation scarcely exists and reversal after it appears is being learned for the first time. These possibilities of accomplishment have been created by taking positive action within the framework of the new physiology.

#### *Current of Injury — Injury of Muscle*

Generalized anoxia of the heart is tolerated even when it is severe; localized anoxia is painful and kills even when it is mild. The development of a fibrillating current is independent of an infarct. The current and the infarct are produced by two different processes, each of which may occur independently, fig. 3. Conversion of a fibrillating cur-

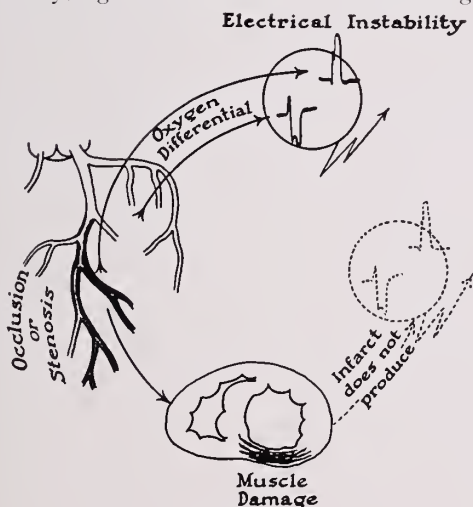


FIGURE 3

Coronary artery occlusion produces two sequelae. One is anginal pain and an electrical charge that may be strong enough to fibrillate the heart. The other is destruction of muscle. Fibrillation may occur without an infarct and an infarct may occur without fibrillation. A mild coronary occlusion, meaning a small infarct, is scarcely mild when it kills.

rent out of oxygen-differentials in muscle is a problem for investigation. The old concept of "current of injury" implies that injury of muscle is involved when abnormal currents are produced. It relates current and injury as results of a single process. This concept of injury is not valid. It implies that cyanosed muscle is injured muscle. A deeply and uniformly cyanosed heart is not injured and does not produce an injury current. This is readily demonstrated in the experimental laboratory and abundant clinical evidence supports these ideas.

#### *Aims of Treatment*

The aims of treatment are cure of anginal pain and prevention of fibrillating currents. If these two desirables can be accomplished, then the patient will live free of anginal pain and safe from fibrillation until structural disease takes his life, and if structural disease stops before it becomes terminal then life expectancy is not shortened by the disease. Treatment is based upon the addition of blood to ischaemic areas of muscle. Quantities in the range of drops or several cc's per minute are effective in reducing pain and making life safer.

#### *Nitroglycerin*

Nitroglycerin and other vasodilating drugs relieve pain by increasing blood supply to ischaemic muscle. These drug effects were measured in my laboratory by D. S. Leighninger and, insofar as I know, these are the only direct measurements in existence. Nitroglycerin adds 0.88 cc. or 10 drops per minute to the circumflex area of muscle when this area of muscle is made ischaemic by ligation of the circumflex artery. This drug effect lasts 5 to 10 minutes when the circulation returns to normal. Relief of pain in man is also temporary. Nitroglycerin and peritrate have temporary action. They do not afford permanent relief of pain and they give no permanent protection against fibrillation. There is no drug that produces permanent intercoronary channels.

#### *The Author's Operation*

The purpose of this operation is to ration the blood that is available. It adds little or no blood to the heart from outside sources. It creates intercoronaries and helps to produce a more even distribution of the blood that is there. The operation is not difficult to perform. It consists of several steps carried out on the surface of the heart. It was described in the Dec. 20, 1958 issue of the J.A.M.A.

#### *Measurements of the Operation*

##### *1. Electrical Death After Test-Artery-Occlusion Under Controlled Conditions.*

In one step, the descending ramus of the left coronary artery is ligated at its origin. Self electro-

*continued on next page*

cution occurred in 70% of the normal dogs. If operation was done weeks or months before the test artery was ligated, the mortality was reduced by 43%. This protection was established by a large number of experiments and is more significant than information obtained from human material. The experiments had controls; human material does not have comparable controls. The fact is established that operation saves life and increases longevity. To deny this is to deny the value of the experimental method.

## *II. Size of Infarct After Test-Artery-Occlusion. Controlled Experimentation.*

In the dogs that survived test artery ligation the size of the infarct was measured in each of the above groups. In the hearts protected by operation done weeks or months before artery-ligation the infarct was 60 to 70% smaller than in the unprotected hearts. The conclusion is that operation protects muscle against destruction by ischaemia, provided operation is done before the artery is occluded. Operation has prophylactic value if done before it is needed. This fact was established under controlled experimentation. It is not possible to obtain information of this nature from human material. This possibility of protection is so reasonable as to be elementary.

## *III. Measurements of Blood Supply to Ischaemic Muscle Under Controlled Conditions.*

The effectiveness of any form of treatment is based upon the amount of blood made available to ischaemic muscle. This can be measured by ligation of the main artery that supplies an area of muscle and then cutting the artery distal to the ligature. The amount of blood that runs out is a measure of the quantity that is available. This blood comes from surrounding muscle where the blood supply is not impaired and it comes by way of intercoronary communications. It is referred to as backflow. The average backflow in normal dogs is 3.8 cc. per minute. After operation the average amount is 8.5 cc. per minute. Operation adds 4.7 cc. per minute or 282 cc. per hour to that which is normally present. These intercoronaries and these back-flows were found one year after operation, and it is assumed that they are permanent. Operation provides five times as much blood as nitroglycerin and the effect is permanent, whereas the effect of nitroglycerin is temporary. The following facts have been established—1, that operation is more effective in adding blood to ischaemic muscle than the vasodilating drugs; 2, that operation is the only method by which the heart can be protected permanently against ventricular fibrillation.

## *IV. Electrical Condition Versus Amount of Blood to Ischaemic Muscle.*

The amount of blood available to an area of

ischaemic muscle can be changed at will in the experimental laboratory. For example, the circumflex area of muscle can be given quantities such as 2, 4, 6, 8, or 10 cc's per minute. An electrogram can be taken from non-ischaemic and ischaemic areas of muscle by passing a cotton electrode moistened in sodium chloride solution from one area to another. Quantities of 2 cc's per minute added to or taken away from ischaemic muscle produce a difference in the electrogram or in the electrical condition of the heart. These changes are readily observed. That the degree of ischaemia has a definite effect on the electrocardiogram is not a controversial point. That quantities of blood in this range produce significant alterations is scarcely appreciated. A nitroglycerin unit of pain relief is based on 10 drops per minute.

## *Operation on Humans*

*1. Selection of Patients.* All patients with the disease should be operated upon except those approaching the terminal stage of inflow-reduction and/or muscle-destruction. These patients are going to die from structural disease. The operation should be done as a prophylactic measure in "coronary families" in which the father and several brothers died at an early age. Protection should be given before it is too late and at a time when operation involves little or no risk. Operation is delayed six months after the last infarct. If there is a question concerning activity in the disease, operation is delayed. The most desirable patient for operation is one with maximum pain and minimum structural disease.

*II. Relief of Pain.* This is experienced by most patients as early as one or two days after operation. Ninety-three per cent of 429 patients operated upon between January 1954 and January 1959 received a good or excellent result. The definition of good is occasional pain, occasional medicament. The definition of excellent is no pain and no medication. These patients were treated by medical measures before operation was done, so that they are in the position to compare the results of medical therapy *versus* the results of surgical operation.

In a survey now being made, patients were asked whether they would recommend this operation to other patients with a similar condition. An affirmative answer was obtained in 110 and a negative answer was obtained in 5. This recommendation is significant. It has additional significance because the disease is progressive and increases in severity. The clinical result was obtained in 110 patients who had gone four years or longer since operation. In this group the clinical result was excellent in 50%, good in 39.5% and fair, which means some improvement, in 8.1%. This analysis indicates that improvement is not transient and that it persists over a period of years.



### *III. Mortality in This Group of 429 Patients is as follows:*

In the hospital, all causes, 6%, subsequent mortality, all causes, up to five years, 10%. One third of the patients were classified as salvage at the time of operation. The definition of salvage is the presence of structural disease that is approaching the terminal stage. In 256 patients classified as non-salvage the hospital mortality, all causes, was 3% and the subsequent mortality, all causes, up to five years was 6%. In a group of 110 patients operated upon in 1954 and 1955, the mortality at the end of two years was 10% and at the end of four years, 22%. In a group of approximately 7,400 patients not operated upon (Black et al., Mayo Clinic, Cole et al., Michael Reese Hospital; Lindgren, Stockholm) the mortality at the end of two years was 25% and at the end of four years, 42%. These groups of patients are scarcely comparable to the operated groups, but the reduction in mortality by operation must have significance because it was substantiated in the experimental laboratory where, under controlled conditions, mortality following test-artery occlusion was reduced 43% by operation and the size of the infarct was reduced by 60 to 70%. It is also probable that structural disease was greater in the operated group than in the non-operated group, because decision to have the operation is often dictated by the degree of incapacity. The greater the pain and the greater the incapacity, the more the patient desires operation. A man (with a family) who is unable to work is driven to have anything done, even operation. The man who can take it easily likes to believe his physician when he states that he does not need operation and that his life is safe under his care.

The incidence of arterial occlusion, in itself, cannot be changed by operation, but the effect on the heart can be reduced by the presence of intercoronary communications. If this is correct, and it undoubtedly is, the statement can be made that operation reduces the damage and danger of subsequent arterial occlusions. They must occur with the same frequency, but they do not always manifest themselves by clinical studies. We have seen patients develop a bout of pain and tachycardia. We have admitted them to the hospital, but the condition clears in twenty-four hours and studies do not confirm the diagnosis of an infarct. This is to be expected on the basis of facts established by experiment. Patients were asked whether they had had a "heart attack" since operation and 109 stated no and 13 stated yes. The average interval since operation was two years.

### *IV. Other Observations After Operation.*

*Increased Capacity for Work.* Almost all patients are able to go back to their previous jobs or are able

to do some kind of gainful work. Some of the patients were completely incapacitated for work before operation, and others were not so incapacitated. With many a patient the anatomy in the heart is good and the anginal pain is comparable to an incapacitating toothache and the result of operation is comparable to that after extraction of the tooth. To be freed from incapacitating anginal pain is scarcely a figment of the patient's mind.

*Cold Feet Before Operation; Warm Feet After Operation.* Many patients stated that their feet were warmer after operation. A study of foot temperatures was carried out. Twenty-three patients were studied who had cold feet before the operation. In 21 of these the temperatures after operation rose 4 to 5 C. The greatest rise was 10 C in one patient and 8 C in each of two others. If the temperatures were normal before operation, they remained normal after operation. What is the significance of warming of cold feet? First, this is an objective measurement which must be accepted as fact. Physiologically, it means that the circulation to the feet is improved by operation on the heart; more blood has reached the feet. The mechanism is not known, but presumably it is by release of spasm.

Many patients state that the entire body is warmer. Some of the patients stated that their memory is improved and that they can comprehend conversation better. Releasing of cerebral spasm is not to be dismissed as an impossibility.

*Absent Radial Pulse Before Operation and Return After Operation.* The radial pulse in the left arm disappeared when a patient had an occlusion of a coronary artery. Blood pressure could not be obtained in this arm, and the pulse was absent for one year when operation was done on the heart. Two days after operation it was noticed that the pulse was present and the blood pressure in the left arm was the same as in the right arm. The obvious explanation of this is that the disease produced arterial spasm of a large artery elsewhere in the body and that this spasm was released by operation on the heart. In terms of physiology, it is significant, first, that this relationship existed and, second, that the surgical operation was effective in releasing it.

*Irregularities of Heart Beat Before Operation; Disappearance After Operation.* In 20 patients operated on, chronic arrhythmia was the most prominent and important symptom before operation. These arrhythmias in most of these patients were distressing and alarming. In 17 patients the arrhythmias either completely disappeared or diminished in frequency and severity after operation. This is presented as objective evidence of benefit from operation.

*Improvement in Ballistocardiogram After Operation.* Ballistocardiograms were done on 17 consecutive patients operated on. In 13 of these the



## CARDIACS CAN WORK\*

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**C**ARDIAC WORK CLASSIFICATION UNITS were established throughout the country to help in solving some of the problems that affect the employment of the person with heart or vascular disease.

The Cardiac Work Classification Unit in Philadelphia,<sup>1</sup> under the sponsorship of the Heart Association of Southeastern Pennsylvania and the Division of Adult Cardiovascular Diseases, Commonwealth of Pennsylvania, started in February, 1952.

The organization committee decided that such a unit would be most productive and useful if admissions were principally confined to persons that were employed or were considered to be employable. A rapport with industry in and around Philadelphia was established for the referral of their workers with heart disease.

The Unit consists of a cardiologist, a psychiatrist, a medical social worker and a vocational counselor. In 1953 a second Unit, composed of the same disciplines, but not the same persons, was established to conduct only follow-up examinations.

It must be stressed that the multi-discipline approach was practiced, and that no recommendation was made individually before the group conference was held. Strict adherence to the policy of the team approach enabled all members of the team<sup>2</sup> to gain experience and insight into the problems of the

worker with heart disease, his resulting disability and its relationship to employability.

The composition, source of referral and job status of 616 persons who were evaluated by the Unit between February, 1952 and December, 1956 is given in Table I. Four hundred and forty-six (72.4%) patients were referred to the Unit by industry (industrial physicians, personnel and labor unions). This source of referral accounts for the fact that 531 (86.2%) of the patients were working full or part time or were on sick leave from full time jobs at the time of initial evaluation. The proportion of males to females, whites to non-whites and age distribution are comparable to other groups and no comment will be made.

Ninety-seven (15.8%) patients were found to have no heart disease. This relatively low figure reflects good screening by the referring sources. The recommendations made to 519 cardiacs (Table II) were that 474 (91.4%) return to full time work, with or without restrictions. In some instances the job could be modified to conform to the recommended restrictions, in others a change of job was accomplished.

Table III represents the composition, source of referral and job status (on initial evaluation) of a group of 374 cases who had one or more follow-up examinations. Comparison with Table I shows little or no change in the composition of these groups in any category, including age, sex, race, source of referral and employment status.

The Unit recommendations (Table IV) made to 331 patients with heart disease, who had one or more follow-up examinations, was that 301 (91%) could return to full time work. Note again that there is no change statistically in comparison with Table II.

The employment status on initial and follow-up evaluation in 374 patients is given in Table V. There was an increase in 56 (14.9%) patients who were employed despite the retirement of 23 patients (22 of whom were employed or on sick leave on initial examination). The changes were in the cases on sick leave and unemployed when first evaluated. Of the 95 cases on sick leave, 57 (60%) returned to work; of the 49 unemployed patients, 29 (60%) were able to get full time work. Thirty-five of those initially on sick leave were in the age group of 55

\*Presented at the Scientific Session of the Rhode Island Heart Association, at Providence, Rhode Island, April 8, 1959.

<sup>1</sup>Supported in part by Grant RD 281, Office of Vocational Rehabilitation.

<sup>2</sup>We are particularly indebted to Miss Hope Thomson and Mr. John Hagan who have been with the Unit since its inception, to Doctors M. C. J. Pfeiffer, R. Monheit, J. Urbach, T. M. McMillan III, D. Lewis, J. Bryfogle, M. Levine, W. S. Robbins, P. Ottenberg, S. Bullock, S. Shapiro, Miss R. Carp, Mrs. J. Wallace, Miss R. Brown, Miss L. Harnick and Miss F. Korsin for their assistance in the operation of the Unit.

TABLE I  
Age, Sex, Race, Source of Referral and Job Status on Initial Evaluation of 616 Cases

Age Group		Sex		Race		Source of Referral				Job Status on Initial Evaluation			
Age No.	Cases	M	F	White	Negro	Industry	Private Doctor	Bur. of Rehab.	Other	Em- ployed Full- Time	Em- ployed Part- Time	Sick Leave	Unem- ployed
20 & under	26 4.1%	17	9	24	2	20	4	0	2	16	0	2	8
21-34	63 10.2%	50	13	47	16	43	17	2	1	49	0	5	9
35-54	313 51.0%	276	37	276	37	223	69	11	10	181	6	82	44
55 & over	214 34.7%	203	11	195	19	160	41	3	10	119	9	62	24
Total	616	546 88.8%	70 11.2%	542	74	446 72.4%	131 21.2%	16 2.6%	23 3.8%	365 59.3%	15 2.4%	151 24.5%	85 13.8%

TABLE II  
Recommendations Made to 519 (84.2%) Cardiacs on Initial Evaluation

Age	Age Group No. Cases	Work Without Restrictions	Same Work With Restrictions	Increased Activity Allowed	Return to Work Full-Time: Reduce Activity	Extend Convalescence, With or Without Care; e.g. Surgery	Unable to Work
20 & under	11 2.1%	3	5	0	1	1	1
21-34	39 7.4%	9	17	1	8	3	1
35-54	262 50.5%	28	131	10	69	18	6
55 & over	207 40.0%	9	122	6	55	7	8
Total	519	49 9.5%	275 53.0%	17 3.3%	133 25.6%	29 5.6%	16 3.0%

TABLE III  
Age, Sex, Race, Source of Referral and Job Status of 374 Follow-up Cases

Age Group		Sex		Race		Source of Referral				Job Status on Initial Evaluation			
Age	No. Cases	M	F	White	Negro	Industry	Private Doctor	Bur. of Rehab.	Other	Em- ployed Full- Time	Em- ployed Part- Time	Sick Leave	Unem- ployed
20 & under	10 2.5%	7	3	8	2	7	2	0	1	4	0	1	5
21-34	44 11.9%	35	9	35	9	32	11	1	0	36	0	3	5
35-54	193 51.6%	170	23	173	20	136	44	6	7	104	6	56	27
55 & over	127 34.0%	119	8	119	8	92	27	1	7	76 *	4	35 †	12 §
Total	374	331	43	335 88.5%	39 11.5%	267 71.5%	84 22.5%	8 1.9%	15 4.1%	220 58.8%	10 2.7%	95 25.4%	49 13.0%

\* 6 applying for new jobs

† 1 applying for a new job

§ 12 applying for jobs

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*continued from page 316*

years and over; of these 17 returned to work. Of the 23 who retired, 18 were in the age group of 55 years or over.

Table VI compares the occupations on initial evaluation with the occupations on follow-up evaluation of 251 cardiac cases who were found to be working at the time of follow-up examination. That the employer need not lose the skill and experience of an employee who develops organic heart disease is shown by the fact that a high percentage of the patients remained in the same job category following evaluation by the Unit. A few cases were placed in jobs where the physical activity was less, but with greater responsibility. The greatest problems were encountered in the unskilled occupations which required great physical exertion and which might aggravate the cardiac condition of the patient. In

these cases, the lack of job opportunities, of skill and training compounded the problem.

The question of how well the patient does clinically, when working and when not working, is summarized in Table VII. Of the 331 patients with heart disease who had a follow-up examination, the number employed increased from 198 on initial examination to 255 on follow-up examination. This was the result of 52 patients returning to work from sick leave, and 25 patients who obtained employment after evaluation by the Unit. The fact that work does not necessarily aggravate heart disease is demonstrated in the second part of Table VII. Of the 77 patients found to be physically improved on follow-up evaluation, 58 (78%) were working; of the 201 patients found to be in the same physical condition, 156 (77%) were working; in the 53 cases who were found to be worse, 31 (60%) of whom were working, it was felt that the natural

TABLE IV  
Recommendations Made to 331 Cardiacs on Initial Evaluation

Age Group		Work Without Restrictions	Same Work With Restrictions	Increased Activity Allowed	Return to Work Full-Time: Reduce Activity	Extend Convalescence, With or Without Care; e.g. Surgery	Unable to Work
Age	No. Cases						
20 & under	6 1.9%	6	1	0	1	1	1
21-34	31 9.4%	8	13	1	6	2	1
35-54	171 51.7%	18	85	4	48	12	4
55 & over	123 37.0%	5	75	4	30	5	4
Total	331	33 10.0%	174 52.6%	9 2.7%	85 25.7%	20 6.0%	10 3.0%

TABLE V  
Employment Status on Initial and Follow-up Evaluation of 374 Cases

Initial Work Status			Follow-Up Status			
	Status	No. Cases	Employed	Sick Leave	Unemployed	Retired
CARDIACS 331 88.5%	Employed .....	198 53.0%	168	6	14	10
	Sick Leave .....	90 24.0%	52	12	14	12
	Unemployed .....	43 11.4%	25	0	17	1
NO HEART DISEASE 43 11.5%	Employed .....	32 8.6%	32	0	0	0
	Sick Leave .....	5 1.4%	5	0	0	0
	Unemployed .....	6 1.6%	4	0	2 * ‡ §	0
Total		374	286 76.5%	18 5.0%	47 12.4%	23 6.1%

\* housewives (7)

‡ psychopathic inferior

§ applying (4)



progression of the heart disease was responsible, rather than the physical exertion of the job.

The relationship of the diagnosis to the medical status on follow-up examination, comparing those patients who were working with those not working, is given in Table VIII. It is of interest to note that 56% of the patients with rheumatic heart disease, 65% of the patients with hypertensive heart disease, 49% of the patients with arteriosclerotic heart disease and 66% of the patients with coronary artery disease were improved or remained the same medically, while working. Eighteen (34%) of the 53 patients found to be worse on follow-up exami-

nation had rheumatic heart disease. Of these, six patients were in age group 21-34 years and ten patients were in age group 35-54 years. This discouraging prognosis, in a relatively young and productive age group, may be reversed by early diagnosis and more definitive treatment, particularly by the development and improvement of techniques in cardiac surgery.

That cardiacs can work was established by the early efforts of the Bellevue Group under Goldwater<sup>1</sup> and has been confirmed not only by our own experience, but by the experience of other Work Classification Units, such as those in Cleveland<sup>2</sup>

*continued on next page*

TABLE VI

Occupation on Initial and on Follow-up Evaluation of 251 Cardiacs Who were Working at Time of Follow-up

Occupation on Initial Evaluation		Occupation on Follow-Up Evaluation						
Occupation	No. Cases	Professional Managerial	Clerical Sales	Service	Skilled	Semi-Skilled	Unskilled	Housewives
Professional	22	21	.....	.....	1	.....	.....	.....
Managerial	9.0%							
Clerical	36	1	32	2	.....	1	.....	.....
Sales	14.3%							
Service	28	.....	.....	27	.....	1	.....	.....
	10.5%							
Skilled	69	3	4	4	53	5	.....	.....
	27.5%							
Semi-Skilled	54		4		2	40	6	2
	22.0%							
Unskilled	37		1	3	1	6	25	1
	14.7%							
Housewives	4			1	.....	.....	.....	3
	1.6%							
Never Worked	1		.....	.....	.....	.....	1	.....
	0.4%							
Total	251	25	41	37	57	53	32	6
	100%							

TABLE VII

Medical Status on Follow-up Evaluation Related to Employment Status on Initial and Follow-up Evaluation of 331 Cardiac Cases

Initial Work Status		Follow-Up Work Status		Medical Status		
Status	No. Cases	Status	No. Cases	Improved	Same	Worse
Employed	198	Employed	168	32†	113	23*
		Sick Leave	6	1	4	1
		Unemployed	14	2	7	5
		Retired	10	1	3	6
Sick Leave	90	Employed	52	17*	31	4
		Sick Leave	12	3	6	3
		Unemployed	14	3	10	1
		Retired	12	2	6	4
Unemployed	43	Employed	25	9*	12	4
		Sick Leave	0	0	0	0
		Unemployed	17	6*	9	2
		Retired	1	1	0	0
Total	331		331	77	201	53

\* 1 case had commissurotomy

† 4 cases had commissurotomies

and Boston<sup>3</sup> and the Altro Group.<sup>4</sup> In a relatively few years, the commonly accepted view of the cardiac as a near total invalid has been altered, so that we now ask ourselves what's wrong with the patient when he is not living a full or nearly full life.

Despite the optimistic picture from the point of view of the physical factors involved in cardiac illness, it is apparent that not all cardiacs who can work do work. The Altro Group classified 35% of their patients as rehabilitation failures. Clark in Boston reported that only 63% of those patients his Group considered employable, did in fact obtain employment.

It was the opinion of the Unit that in slightly over 46% of the patients evaluated, physical factors and job opportunities were less important than social, economic, cultural and emotional factors in employment motivation and vocational adjustment. Although 91% of the patients evaluated were judged to be physically able to return to work, it was found that in approximately 30 per cent, the recommendations of the Unit had not been followed. In the past year the Unit\* has studied a group of 117 patients in an effort to determine the medical, vocational, social and psychiatric factors related to unsuccessful vocational adjustment of cardiac patients.

The term "successful vocational adjustment" (SVA) is defined as "the return to work without aggravation of cardiac disease." If the job placement is consistent with the Unit's recommendations, then patients who return to work with or without restrictions, or to the same job with reduced activities are considered to fall into the SVA group. The patient may continue to show signs and symptoms of cardiac illness after return to work and still be placed in this group, if the cardiologist judges that the heart disease is not being aggravated by the work performed, but would be anticipated on the basis of the patient's physical status, even if he were not working.

Those revealing "unsuccessful vocational adjustment" (UVA) are rated by one or more of the following criteria:

- (a) The patient is not working, although able to do so physically;
- (b) The patient is not working up to the level recommended;
- (c) The patient is working significantly beyond the recommended level, with aggravation of heart disease.

Of the 117 patients studied, 38 (32%) were judged to be UVA. The data from the team evaluation schedules revealed that the group classified as UVA differed from the group classified as SVA in

that the former group showed a significantly greater frequency of problems in the social and vocational areas. The UVA group had multiple problem areas; their problems appeared to be more severe, and there was a greater tendency for the cardiac illness to aggravate these problems. The SVA group more often realistically accepted the illness, while the UVA group was overconcerned.

From the schedules for each discipline the following information emerged:

1. The cardiologist classified a number of patients as III C (New York Heart Association Classification). This degree of incapacity did not necessarily render the patient UVA since a number with this classification were SVA. Additionally, in the UVA group, it was judged that these patients could be gainfully employed without aggravating their cardiac condition. It was obvious, therefore, that the reason these patients were not working was due to non-cardiac factors. A striking finding was, that there were six times as many patients with hypertensive heart disease in the SVA group than in the UVA group. The factor or factors responsible for this finding remain to be evaluated.
2. According to the data obtained by the vocational counselor, job stability was an important factor that differentiated the two groups. The SVA group changed jobs much less often than the UVA group, both before and after the onset of heart disease. This may be related to the finding that three times as many patients in the UVA group had major problems in personal relationships on the job, before cardiac illness, than in the SVA group.
3. Data from the social worker's schedules concerning economic and family stability factors showed that generally the SVA group experienced little or no economic deprivation, and, if family stability was affected, it was likely to be in a positive direction. The UVA group suffered greater economic hardship and their families were forced to make sacrifices. In both groups, cardiac illness led to a shift in the roles assumed by family members. The SVA group gave up responsibilities for household activities, while the UVA group tended to assume them.
4. From the psychiatrist's schedule, the data indicated that an individual with heart disease who made a poor vocational adjustment following his illness or its diagnosis was found clinically to be a passive, dependent individual who appeared anxious or depressed on interview. He was less likely to give the general

\*Miss H. Thomson, Mr. J. Hagan, Doctors D. Lewis, S. Shapiro, R. Monheit, M. Levine, Miss F. Korsin.

TABLE VIII

Medical Status and Employment Status on Follow-up Evaluation Related to Diagnosis of 331 Cardiac Cases

Diagnosis		Medical Status on Follow-up					
		Improved		Same		Worse	
Heart Disease	No. Cases	Working	Not Working	Working	Not Working	Working	Not Working
Congenital	4 1.0%	0	0	4	0	0	0
Rheumatic	70 21.0%	17	4	22	9	10	8
Hypertensive	64 20.0%	9	3	33	9	9	1
Arteriosclerotic	39 12.0%	0	1	19	8	3	8
Coronary artery disease	142 43.0%	29	11	65	26	7	4
Other	12	3	0	6	0	2	1
Total	331	58 16%	19 7%	149 39%	52 21%	31 10%	22 7%

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impression of being frank, spontaneous or friendly. His defenses typically were those of regression or projection. Following his illness he was found to have cut down his activities excessively and to have had a poor convalescent record due to trying to get back to work too early, or by prolonging unnecessarily his return to work. On the other hand, the SVA patient made a good impression, appeared normal in mood and showed the defenses and personality characteristics of the obsessive compulsive. Following cardiac illness his convalescence was of appropriate length and he did not unduly restrict his activities.

This research project emerged from our interest in investigating this UVA group to learn what were the important factors involved in their failure to return to work as recommended. Knowledge of the factors which impede rehabilitation and vocational adjustment to cardiac disease would enable early recognition of the problem cases. This would facilitate prompt preventive measures to reduce this group to a minimum. If this hard core group of patients could be returned to suitable work, it would represent the conversion of a social and economic liability to an industrial and economic asset.

**CONCLUSIONS**

The Cardiac Work Classification Unit, using group evaluation from the physical standpoint, the mental and emotional background, influenced by socio-economic factors, together with recommendations for treatment when needed (cardiac surgery, psychotherapy), training or change in jobs if indicated, offers a superior approach to the proper placement in industry of the person with heart

disease.

The uniform experience of such Units throughout the country is that most cardiacs can work without aggravating their heart disease. By improving the education of the patient, the physician and the employer, the Units have helped to remove some of the barriers to the employment of the worker with heart disease.

**BIBLIOGRAPHY**

- <sup>1</sup>Staff of the Work Classification Unit, Adult Cardiac Clinic, Bellevue Hospital. An occupational analysis of 580 cardiac patients. *Circulation*, 1951, 3:291
- <sup>2</sup>Parran, T. V.; Hellerstein, H. K.; Cohen, D.; Goldston, E.: Analysis of 595 subjects studied at the Work Classification Clinic of the Cleveland Area Heart Society. Paper read at the First Wisconsin Conference on Work and the Heart, Marquette University, May, 1957
- <sup>3</sup>Clark, R. J.: A statistical summary and analysis of experience at the Cardiac Work Classification Unit, Boston, Massachusetts, with special reference to coronary heart disease. Paper read at the First Wisconsin Conference on Work and the Heart, Marquette University, May, 1957
- <sup>4</sup>Black, B. J.; Jezer, A.; Adelson, D.: Evaluative study of the Altro Cardiac Project. Paper read at the First Wisconsin Conference on Work and the Heart, Marquette University, May, 1957.

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## RECENT ADVANCES IN ARTERIAL SURGERY\*

W. STERLING EDWARDS, M.D.

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IN THE PAST few years arterial disease has come under direct surgical attack for the first time. Previously, indirect operations such as sympathectomy and amputation were all that could be offered patients with arterial obstruction; and aneurysms could only be wrapped or wired internally. Beginning twenty years ago with the first use of autogenous veins to replace injured arteries more direct techniques for restoring blood flow to the extremities and to various organs of the body have developed. The introduction of methods for preserving arterial homografts gave a tremendous stimulus to this field of arterial surgery, beginning with Gross's work with fresh homologous arteries in humans. Gross reported human arterial replacement in long segments of coarctation of the aorta in 1948.<sup>4</sup> A number of these early patients are still doing well a decade later. The expanding need for arterial substitutes, however, soon surpassed the supply of the available homografts in most communities. Other more disturbing changes in homografts such as late degenerative changes also began to appear. Aneurysmal formation or occlusive atherogenesis in homografts has led to a search for more satisfactory arterial substitutes.

The original demonstration by Voorhees, Jaretzki, and Blakemore<sup>7</sup> that synthetic cloth tubes would serve as durable replacements for arteries was the next forward step. These investigators demonstrated that tubes tailored of Vinyon "N" or any other synthetic cloth with low tissue reaction could be fashioned on a sewing machine in the operating room, after exposure of diseased vessels, into a tube-shaped arterial replacement. This was a major advance, but a number of technical problems remained in making a really practical and versatile graft of synthetic material. Cuffs and seams made

the tailored prosthesis difficult to suture. Ordinary cloth is usually so porous that considerable blood loss occurs at the time of insertion. A collapsible cloth tube, if not placed under exactly the right tension, is subject to wrinkling or buckling with resulting thrombosis. Using the collapsible fabric, flexion of the graft across a joint such as the knee would be dangerous, and bypass grafts around obstructed segments would be difficult to accomplish.

Five years ago we were very fortunate in obtaining the assistance of the Chemstrand Corporation Research Laboratory in solving many of these technical difficulties. Braided nylon tubes were developed with crimps or corrugations to prevent kinking.<sup>1,2</sup> The tube ends could be heat-sealed to eliminate the need for cuffs to prevent fraying. "Y"-shaped tubes were developed for replacement of the frequently diseased aortic bifurcations. This nylon graft, which could be manufactured in various dimensions and shapes, allowed attack on an increasing number of aortic and peripheral arterial lesions. Nylon was selected as the first fiber to use by our group since it was known that nylon had greater tensile strength than any other fiber and greater mechanical durability. Subsequent studies have shown, however, that nylon is not the ideal fiber. Despite its initial superior tensile strength, reaction to tissue fluids causes slow decrease in strength in the first two years after implantation. This is also true in less degree of orlon, vinyon, and dacron. Only teflon (Du Pont's trade name for its polytetrafluorethylene fiber) shows no tissue reaction whatsoever, no water absorption, and no loss of tensile strength after several years implantation in animal or human tissue. Recently, methods have been developed for crimping tubes of teflon, using a high degree of heat to accomplish this. Knitted and woven tubes of teflon have been used clinically now for eighteen months and appear to be much superior to the original nylon grafts and in many aspects superior to any other synthetic that we have at present tried.<sup>3</sup> These tubes have been manufactured in two constructions, knitted and woven, to determine by experience which is superior. Knitted grafts hold sutures well at the cut ends, without heat-sealing or any other modification. Knitted tubes have the disadvantage, how-

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ever, of moderate porosity with some blood loss at the time of removal of the clamps, despite all efforts at preclotting of the graft. The second disadvantage of a more porous tube such as the knitted grafts has recently become apparent. The degree of porosity determines the amount of scar tissue which forms between the fibers of the graft. The more porous the graft the greater will be the ultimate stiffness and lack of flexibility that will develop as months and years pass.

Our favorite graft at the present time is a tightly woven graft of teflon.\* This graft has the very distinct advantage of having very low porosity. There is no need to preclot this tube since bleeding is minimal and the graft has been satisfactorily used in heparinized patients and in patients with hypertension without blood loss. The porosity, though low, is adequate for the nourishment of the new intimal lining that forms inside any graft as demonstrated by animal experiments in the past two years. This woven tube also holds sutures well if moderate care is taken with the ends.

Teflon has several advantages over any of the other synthetic fiber tube. The lining that forms on the inside of teflon is extremely thin, less than a millimeter in thickness. It becomes adherent much sooner than in tubes of dacron, orlon or nylon and the healing of this lining is completed months sooner than in most other synthetics. One advantage of teflon over any other graft is its very low flex abrasion resistance, that is the cutting of one fiber against another. Teflon is the superior fiber, therefore, for arterial grafts at the present time.<sup>5</sup>

### *Aneurysms*

Grafts are currently used for replacement of aneurysms of the aorta regardless of their location and for the replacement of peripheral aneurysms arising primarily in the popliteal or femoral artery. Patients with an asymptomatic abdominal aortic aneurysm, larger than 6 centimeters in diameter, have a life expectancy up to three years, at the end of which time a majority of these individuals will have died. Symptoms of vague abdominal or back pain usually indicate expansion or dissection and close to 100% will be dead in six months. Surgery should be performed in all abdominal aneurysms, therefore, where some other urgent contraindication does not exist.

Popliteal aneurysms are complicated by thrombosis with severe arterial insufficiency and necrosis with gangrene. Popliteal aneurysms, even when asymptomatic, should be resected and replaced by a graft.

Aortic aneurysms involving the descending

thoracic aorta can now be replaced with relative safety by protecting the spinal cord and kidneys with a pump bypass from left auricle to femoral artery. Aneurysms of the aortic arch have as yet a formidable mortality in all clinics, and the risk in each case must be individually assessed.

The most frequent use of arterial grafts has been for the establishment of blood flow beyond obstructions in various areas of the arterial circulation. Obstructions of the lower aorta, iliacs and femoral vessels as far down as the popliteal artery below the knee can be bypassed. We have satisfactorily used grafts to bypass obstructions of the vessels of the arch of the aorta to the carotid and upper extremity. Transient arm or leg weakness, blindness or aphasia often indicates internal carotid obstruction in the neck and bypasses have been constructed from the subclavian artery to the distal internal carotid beyond the obstruction.<sup>6</sup>

### *Arteriography*

More and more frequently it has been demonstrated that every limb in which the popliteal pulse is absent should be subjected to arteriographic study before therapy is planned or before the leg is amputated. All too frequently the object of arteriography is poorly understood. An arteriogram should, of course, demonstrate the site of origin and length of arterial obstruction, but these objectives are less important than adequate visualization of the arterial pathways distal to the obstruction. If the popliteal branches in the calf are obstructed, any type of graft or thrombectomy procedure will be doomed to failure from inadequate runoff. The arterial system should be visualized down to the ankle in cases of femoral obstruction. A cassette changer, manually operated, which will allow exposure of 36-inch films at one-second intervals has been a great help in obtaining complete information in regard to the arterial circulation of the entire leg.

Demonstration of obstruction of the internal carotid arteries is usually accomplished by percutaneous carotid arteriography into the common carotid arteries. If there is a discrepancy in the strength of the common carotid pulsations, or if blood pressure is unequal in the two arms, or if the patient has symptoms of dizzy spells, vertigo or falling to one side suggesting basilar artery insufficiency originating possibly in the vertebral arteries, we feel that arteriography of the arch of the aorta and its branches is indicated. This seems to be accomplished best by retrograde catheterization of the arch of the aorta with a small cardiac catheter through the radial artery in the antecubital space. A pressure injector is necessary to outline these vessels because of the rapid flow of blood, but very clear demonstration can be obtained of the arch vessels with this technique, using 50% Hypaque.

*concluded on next page*

\*These tubes have been manufactured by U. S. Catheter & Instrument Corp., Glens Falls, New York and distributed by C. R. Bard, Inc., Summit, New Jersey.



### *Incidence of Thrombosis*

One discouraging feature of many reports on the surgery of peripheral arteriosclerosis has been the relatively high incidence of late thrombosis. At present, in a group of about 75 patients with peripheral arteriosclerosis bypassed by grafts, there have been about 25 per cent of late occlusions from four to eighteen months after operation. Arteriography carried out on patients postoperatively, at regular intervals, demonstrates no evidence of plaque formation within the grafts. We have been able, however, to see the development of plaques in the arteries or proximal to the graft, especially in the areas where arterial clamps were placed across the artery. It is felt that trauma to these sclerotic vessels has produced a more rapid progression of atheromatous formation in these areas than would otherwise have occurred. Therefore, technically, it is vitally important to produce minimal trauma to sclerotic vessels if the grafts are to function for long periods of time. What is needed, of course, is a medical method of preventing further progression of arteriosclerosis after the placement of such grafts, and until such time as this is developed there will inevitably continue to occur occasional cases of late graft occlusion, regardless of the type of graft used.

#### BIBLIOGRAPHY

- <sup>1</sup>Edwards, W. S., and Tapp, J. S.: Chemically Treated Nylon Tubes As Arterial Grafts. *Surgery*, 38:61, 1955
- <sup>2</sup>Edwards, W. S.: Plastic Arterial Grafts. Charles C Thomas, 1957
- <sup>3</sup>Edwards, W. S., and Lyons, C.: Three Years' Experience With Peripheral Arterial Grafts of Crimped Nylon and Teflon. *Surg., Gynec., & Obst.*, 107:62, 1958
- <sup>4</sup>Grass, R. E.; Hurwitt, E. S.; Bill, A. H., and Peirce, E. C.: Preliminary Observations On The Use of Human Arterial Grafts in The Treatment of Certain Cardiovascular Defects. *New Eng. J. Med.*, 239:578, 1948
- <sup>5</sup>Harrison, J. H.: Synthetic Material As Vascular Prostheses. II. A Comparative Study of Nylon, Dacron, Orlon, Ivalon Sponge, and Teflon in Large Blood Vessels with Tensile Strength Studies. *Amer. Jour. Surg.*, 95:16, 1958
- <sup>6</sup>Lyons, C., and Galbraith, G.: Surgical Treatment of Atherosclerotic Occlusion of The Internal Carotid Artery. *Ann. Surg.*, 146:487, 1957
- <sup>7</sup>Voorhees, A. B.; Jeretski, A., and Blakemore, A. H.: The Use of Tubes Constructed of Vinyon "N" Cloth in Bridging Arterial Defects. *Ann. Surg.*, 135:332, 1952

### RHODE ISLAND MEDICAL JOURNAL THE TREATMENT OF CORONARY HEART DISEASE

*concluded from page 315*

record was abnormal; in 3 it was normal. Significant improvement in the record occurred after operation in 11 of the 13 patients who showed abnormal records before operation. In two, the record did not change. The improvement in the ballistocardiogram indicates improved contractility of the myocardium. This study is presented as objective (not subjective) evidence of benefit from operation.

#### CONCLUSIONS

Anginal pain is most effectively treated by surgical operation. This operation provides the only protection against ventricular fibrillation occurring in hearts that structurally are too good to die. This operation should be done in your community and a two-day training course will become available to internists and surgeons upon application.

#### *Addendum*

Statistical studies indicate that the anticoagulant drugs are effective in reducing pain and mortality in patients with this disease. The physiology of anticoagulants and of surgical operation is not the same, and each should be used in treatment. One preserves the last vestige of blood through a diseased artery; the other creates intercoronaries. Together they should provide the greatest pain relief and protection to your patients.

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### *Providence Medical Association*

## GOLF TOURNAMENT and ANNUAL DINNER

*Wednesday . . . June 24*



*Masters in Medicine . . .*

## PUERPERAL FEVER, AS A PRIVATE PESTILENCE\*

OLIVER WENDELL HOLMES, M.D.

*Parkman Professor of Anatomy and Physiology in Harvard University*

(Boston: Ticknor and Fields, MDCCCLV)

IN COLLECTING, enforcing and adding to the evidence accumulated upon this most serious subject, I would not be understood to imply that there exists a doubt in the mind of any well-informed member of the medical profession as to the fact that puerperal fever is sometimes communicated from one person to another, both directly and indirectly. In the present state of our knowledge upon this point I should consider such doubts merely as a proof that the sceptic had either not examined the evidence, or, having examined it, refused to accept its plain and unavoidable consequences. I should be sorry to think with Doctor Rigby, that it was a case of 'oblique vision;' I should be unwilling to force home the *argumentum ad hominem* of Doctor Blundell, but I would not consent to make a *question* of a momentous fact, which is no longer to be considered as a subject for trivial discussion, but to be acted upon with silent promptitude. It signifies nothing that wise and experienced practitioners have sometimes doubted the reality of the danger in question; no man has the right to doubt it any longer. No negative facts, no opposing opinions, be they what they may or whose they may, can form any answer to the series of cases now within the reach of all who choose to explore the records of medical science.

\* \* \*

The practical point to be illustrated is the following: *The disease known as puerperal fever is so far contagious as to be frequently carried from patient to patient by physicians and nurses.*

Let me begin by throwing out certain incidental questions, which, without being absolutely essential, would render the subject more complicated, and by making such concessions and assumptions as may be fairly supposed to be without the pale of discussion.

1. It is granted that all the forms of what is called puerperal fever may not be, and probably are not, equally contagious or infectious. I do not enter into

the distinctions which have been drawn by authors, because the facts do not appear to me sufficient to establish any absolute line of demarcation between such forms as may be propagated by contagion and those which are never so propagated. This general result I shall only support by the authority of Dr. Ramsbotham, who gives, as the result of his experience, that the same symptoms belong to what he calls the infectious and the sporadic forms of the disease, and the opinion of Armstrong in his original essay. If others can show any such distinction, I leave it to them to do it. But there are cases enough that show the prevalence of the disease among the patients of a single practitioner when it was in no degree epidemic in the proper sense of the term. I may refer to those of Mr. Robertson and of Dr. Peirson, hereafter to be cited for examples.

2. I shall not enter into any dispute about the particular mode of infection, whether it be by the atmosphere the physician carries about him into the sick-chamber, or by the direct application of the virus to the absorbing surfaces with which his hand comes in contact. Many facts and opinions are in favor of each of these modes of transmission. But it is obvious that, in the majority of cases, it must be impossible to decide by which of these channels the disease is conveyed, from the nature of the intercourse between the physician and the patient.

3. It is not pretended that the contagion of puerperal fever must always be followed by the disease. It is true of all contagious diseases that they frequently spare those who appear to be fully submitted to their influence. Even the vaccine virus, fresh from the subject, fails every day to produce its legitimate effect, though every precaution is taken to insure its action. This is still more remarkably the case with scarlet fever and some other diseases.

4. It is granted that the disease may be produced and variously modified by many causes besides contagion, and more especially by epidemic and endemic influences. But this is not peculiar to the disease in question. There is no doubt that smallpox is propagated to a great extent by contagion, yet it goes through the same periods of periodical increase

\*The Rhode Island Medical Library possesses a copy of Dr. Holmes' remarkable essay, presented to the Library by the late Doctor Herbert G. Partridge.

and diminution which have been remarked in puerperal fever. If the question is asked how we are to reconcile the great variations in the mortality of puerperal fever in different seasons and places with the supposition of contagion, I will answer it by another question from Mr. Farr's letter to the Registrar-General. He makes the statement that "five die weekly of smallpox in the metropolis when the disease is not epidemic," and adds, "The problem for solution is, why do the five deaths become 10, 15, 20, 31, 58, 88, weekly, and then progressively fall through the same measured steps?"

5. I take it for granted that, if it can be shown that great numbers of lives have been and are sacrificed to ignorance or blindness on this point, no other error of which physicians or nurses may be occasionally suspected will be alleged in palliation of this; but that whenever and wherever they can be shown to carry disease and death instead of health and safety, the common instincts of humanity will silence every attempt to explain away their responsibility.

\* \* \*

There may be some among those whom I address, who are disposed to ask the question, What course are we to follow in relation to this matter. The facts are before them, and the answer must be left to their own judgment and conscience. If any should care to know my own conclusions, they are the following; and in taking the liberty to state them very freely and broadly, I would ask the inquirer to examine them as freely in the light of the evidence which has been laid before him.

1. A physician holding himself in readiness to attend cases of midwifery should never take any active part in the post-mortem examination of cases of puerperal fever.

2. If a physician is present at such autopsies, he should use thorough ablution, change every article of dress, and allow twenty-four hours or more to elapse before attending to any case of midwifery. It may be well to extend the same caution to cases of simple peritonitis.

3. Similar precautions should be taken after the autopsy or surgical treatment of cases of erysipelas, if the physician is obliged to unite such offices with his obstetrical duties, which is in the highest degree inexpedient.

4. On the occurrence of a single case of puerperal fever in his practice, the physician is bound to consider the next female he attends in labour, unless some weeks at least have elapsed, as in danger of being infected by him, and it is his duty to take every precaution to diminish her risk of disease and death.

5. If within a short period two cases of puerperal fever happen close to each other, in the practice of

the same physician, the disease not existing or prevailing in the neighborhood, he would do wisely to relinquish his obstetrical practice for at least one month and endeavor to free himself by every available means from any noxious influence he may carry about with him.

6. The occurrence of three or more closely connected cases, in the practice of one individual, no others existing in the neighborhood, and no other sufficient cause being alleged for the coincidence is *prima facie* evidence that he is the vehicle of contagion.

7. It is the duty of the physician to take every precaution that the disease shall not be introduced by nurses or other assistants by making proper enquiries concerning them and giving timely warning of every suspected source of danger.

8. Whatever indulgence may have been granted to those who have heretofore been the ignorant causes of so much misery, the time has come when the existence of a *private pestilence* in the sphere of a single physician, should be looked upon not as a misfortune but as a crime; and in the knowledge of such occurrences, the duties of the practitioner to his profession, should give way to his paramount obligations to Society.

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# The RHODE ISLAND MEDICAL JOURNAL

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## THE NEW YORK MEDICAL TESTIMONY PLAN

AT A RECENT stimulating meeting of the Providence Medical Association the New York medical testimony plan was described by Doctor Howard R. Craig, director of the New York Academy of Medicine, and Honorable Aron Steuer, Justice of the Supreme Court of the State of New York, both architects and apologists of the plan. Previous to the establishment of this plan, the courts had been plagued by conflicting testimony of medical experts, at times so much at variance that an attempt to arrive at the truth became almost impossible. If trained jurists found this adversary approach frustrating, it is obvious that it was completely absurd to expect a jury of laymen to know what was going on.

The plan as eventually developed was originally conceived within the state judiciary in New York City. Under the impetus of Justice David W. Peck, now retired but formerly presiding justice of the Supreme Court of the State of New York, the medical profession was approached through Doctor Craig, and immediate co-operation was pledged. The plan which eventually evolved was instituted by judicial regulation rather than legislation, because of the reluctance of legislators to change long-standing court procedure.

One hundred specialists in the New York area of professorial or attending rank were solicited as panelists in the new venture. It was felt that only by choosing men of the highest professional standing could the weight of their views be made com-

PELLING. Ninety-seven of the original one hundred consented to participate. The panelists functioned under judicial invitation and as friends of the court. Everything possible was done to accommodate the convenience of the panelists and to facilitate proper examination and consultation. Adequate remuneration was provided.

It was found immediately that the effect of imposing a two to one decision on the side of the neutral examiner, particularly in view of his prestige, was usually decisive. As a result, many cases were settled out of court on the basis of the pre-trial examination. It has also had a salutary effect on the filing of nuisance cases, and on reducing the backlog of pending litigation. There was no stricture, however, on bringing the case to court, and the panelist was subject to the usual cross-examination. Judge Steuer made the interesting observation that the new system "had a markedly therapeutic effect on both our professions."

Considerable interest has been shown in this new approach in other areas of the country. In fact, legal guests who attended our recent meeting, such as Commissioner George A. Roche of the Workmen's Compensation Commission, Ambrose W. Carroll, chairman of the Executive Committee of the Rhode Island Bar Association, and William H. Edwards, president of the Rhode Island Bar Association, all expressed interest in the plan. Whether or not the problem in Rhode Island is of sufficient magnitude to warrant a reform of this nature is not now clear.

*continued on next page*



In addition, the task of finding a sufficient number of individuals with suitable medical talent to make the plan workable may be difficult in a community of this size. The plan certainly warrants study,

however, and we hope that the legal profession here will see fit to look further into this most important innovation.

## EMOTION AND COMMOTION

THE EXCELLENT REPORT of the special committee of the Society appointed to study health insurance problems of the aged, adopted by the House of Delegates and referred to the Committee on Medical Economics for possible procedures of implementation, contains many factual down-to-earth comments regarding the over age 65 person that warrant careful consideration.

In an era when emotion and commotion predominate, and the hysteria, mild or otherwise, that is generated by such confusion frightens the average citizen into believing that the solution of his economic problems rests in the socialism of a paternal federal government, the report of the Society's committee makes for thoughtful reading.

The review of the processes of aging, and their natural sequelae, the analysis of physicians' costs *versus* over-all health costs, the development of the voluntary prepayment plans offering service benefits particularly helpful to the retired or older age person—all indicate clearly that the health problems of the elderly can be resolved sensibly by wise planning.

It is unfortunate that the emotional factor is overplayed to such an extent that any person approaching, or looking forward to a sixty-fifth birthday must indeed feel that he is entering a catastrophic era that makes no allowance for growing old gracefully, and in reasonably good health.

In its report the Committee expressed the hope that the physicians of Rhode Island may have "co-operation by the public, by our political representatives, and by our newspapers in solving this problem wisely, and not impulsively by hasty action."

Unfortunately the political representatives and newspapers are far more emotional, and commotional, than the public. Thus we find our Congressional representative from the first Rhode Island district praising the fine record of Rhode Island in providing voluntary health insurance for the aged, but advocating instead a federal compulsory taxation program of unlimited cost to provide hospital and surgical benefits for all social security beneficiaries over the age 65.

We find our largest daily newspapers in the state advocating passage of Mr. Forand's bill of federal taxation without benefit of prudent study of the long-range cost involved for all citizens, and without consideration of what has been done in Rhode Island, or what can be done here and elsewhere to meet the problem of the aged or any other group

without running to the District of Columbia for a solution. And the commotion of the newspapers stirred the passage of a General Assembly resolution without any hearing or discussion, advocating that the Congress enact Mr. Forand's bill.

In the face of such impulsive local action by the press and politicians it is refreshing to note that the general public is not only aware of the basic issues of health insurance and the problems of the aged, but it has and will continue to do something about those problems with the help of good leadership.

As reported by the executive director of Blue Cross a month ago, of the more than 70,000 people in the state who are over the age 65, "approximately 56,500 are enrolled in Blue Cross and 41,000 are enrolled in Physicians Service," and there is no age limit for any subscribers to either plans, nor any reduced benefits because of age. In addition, the Health Insurance Institute reported earlier this year that in 1958 benefit payments by insurance companies to the people of Rhode Island covered by health insurance policies reached a new high. These facts clearly indicate that the public is co-operating in the voluntary movement to provide their health insurance needs, as well as their freedom from federal socialism.

As the Society's study committee noted in its report to the House of Delegates—

"... while medicine will do its part to bring about continued improvements in voluntary health insurance programs, we must have equally strong support from employers, labor organizations, insurance companies, and the people themselves. We believe that society has the responsibility to provide necessities, of which medical care is only one, to those persons who are unable to provide for themselves.

"We are convinced that the people requiring such assistance are a small portion of the total in any age group, and our common efforts must be directed toward developing programs for keeping elderly people well and productive through proper health maintenance and proper living..."

And as the Department of Health, Education and Welfare noted to the Congress in its report on programs to assist the aged meet medical bills,

"in our society the existence of a problem does not necessarily indicate that action by the federal government is desirable."

*concluded on page 330*



## *Popularity is a Challenge*

First offered in 1950, Physicians Service has grown tremendously fast because it offers real help in meeting costs of a wide range of surgical-medical procedures.

Today, Physicians Service has the greatest percentage of enrollment of any similar plan in the country.

Great growth has been a challenge. It is a challenge to the doctors sponsoring the Plan to provide adequate, timely medical-surgical-obstetrical benefits for everyone who asks for them. What is particularly significant, Physicians Service protection has been extended to 80% of those living in Rhode Island who are over 65 years of age. No other similar program has extended its coverage so broadly.

Great growth is also an answer to a problem. For in spreading risks over more than a half million persons, costs have been cut down to a point where benefits are within the reach of everyone. And they are kept within reach, too, because Physicians Service subscribers can maintain their membership if they change jobs or retire.

In almost every instance, hospitalized patients require surgical, medical or obstetrical care. Physicians Service helps pay doctors' bills, pays for hundreds of different operations, provides X-rays and covers non-surgical visits in the hospital.

As time goes on, Physicians Service will continue to bring the most effective coverage possible to the most people.

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# *Physicians Service*



## EDITORIALS

*concluded from page 328*

## A WELL-DESERVED HONOR

The absence of a medical school notwithstanding, several Rhode Island physicians have attained to offices of distinction in national medical societies. The latest recipient of this honor is Doctor Marshall N. Fulton, physician-in-chief at the Rhode Island Hospital, who was recently appointed chairman of the board of governors of the American College of Physicians.

Doctor Fulton was graduated from Brown University in 1920, and then for three years was a Rhodes Scholar at Merton College, Oxford University. He received his medical degree from Johns Hopkins University, served his internship at the Peter Bent Brigham Hospital, and beginning his military service as a major, advanced to colonel in the medical service of the Walter Reed Hospital and later became chief of medicine at the Valley Forge Hospital, Phoenixville, Pennsylvania. It was while he was stationed at Ashford Hospital in White Sulphur Springs, Virginia, that President Eisenhower became his patient.

On his return to Providence in 1946, Doctor Fulton became president of the Rhode Island Heart Association. He is a member of the Providence Medical Association, the Rhode Island Medical

Society, the American Medical Association, the New England and American Heart Associations, the Society of Clinical Investigation and the Association of American Physicians. He is a member of the board of trustees of Butler Health Center and a former trustee of Brown University.

On behalf of his colleagues throughout Rhode Island, the editors of the RHODE ISLAND MEDICAL JOURNAL extend to Doctor Fulton their congratulations upon his receipt of a distinguished honor, so eminently deserved.

## PLEASE RETURN TO LIBRARY

The following journals, sent to Rhode Island Hospital on Interlibrary Loan, were taken from Peters House Library without permission:

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*All numbers*

## BOOK REVIEW

CURRENT THERAPY—1959. Edited by Howard F. Conn, M.D. W. B. Saunders Co., Phil., 1959. \$12.00

I am sure that the above book isn't new to most of the physicians in the area. For years now, CURRENT THERAPY has been published yearly and accepted with great enthusiasm. The basic structure hasn't changed, for it is still divided into sixteen sections covering the major systems in medicine.

It was not possible to scrutinize each section completely in a short period of time, but a few were reviewed *in toto* and the others scanned briefly. One can be sure that the editor and his consultants have endeavored to complete each section fully. This is evidenced by the presence of some of the latest concepts in each division. In addition to this, the latest drugs have been included, together with their accepted dosages.

Thus, this is a handy reference book wherein it is possible to gain access to factual knowledge at a moment's notice. The last chapter is most practical in that it covers miscellaneous poisons, ingredients in commercial products, a roster of new drugs, pediatric doses and a table of metric and apothecary systems.

I believe that no physician's library can be complete without this well-edited, comprehensive book.

HENRY J. KRAWCZYK, M.D.

## How Much Federal Aid Did the Pilgrims Get?

Extension of Remarks

of

HON. HARRY FLOOD BYRD

of Virginia

in the Senate of the United States

*Friday, April 24, 1959*

Mr. BYRD of Virginia. Mr. President, I ask unanimous consent to have printed in the Appendix of the RECORD a statement which appeared in the U.S. NEWS & World Report entitled "How Much Federal Aid Did the Pilgrims Get?"

There being no objection, the statement was ordered to be printed in the RECORD, as follows:

*How Much Federal Aid Did the Pilgrims Get?*

They were in a depressed area. No one guaranteed them high prices for anything. Their only roads and schools were built by themselves. For security they did their own saving, or starved.

All they had was character. All they did was work. All they wanted was self-respect.

The sum of those three traits became America.

But what's going to be the sum of the traits you see today — the traits of character, or, rather, lack of it, that demand more money for less work, put security above self-respect, pamper self-pitying criminals instead of punishing them, give away resources we desperately need to protect ourselves, listen to weaklings that want Government to take care of them when they should take care of themselves.

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*President of the Rhode Island Medical Society*  
1959 - 1960

## PRESIDENT'S MESSAGE

**T**RADITIONALLY the president-elect of the Rhode Island Medical Society is given a page in the *Journal* to preface his induction into office as president. This offers an opportunity to express his gratitude for being so honored, his diffidence in the face of the complex problems ahead of him, his need of co-operation from the other officers and committees, and his heartfelt hope that he can do half as well in this instance as his ninety-nine predecessors.

During the year before his induction, by a wise provision, the president-elect serves an apprenticeship and sees something of the president's numerous and time-consuming duties. This makes for continuity of experience, and one would think would overcome any timidity by an increased familiarity with these duties. However, only the realization that the Society's standing committees are made up of experienced workers, and I mean workers, and that our indefatigable executive secretary is alert to every contingency, partially overcomes this temerity. It is well perhaps that he writes of his hopes on taking office, as it is probably more cheery reading than his retrospective report would be a year later.

The Society's problems differ from generation to generation, from year to year. You may read in the Society's charter in 1812 that it deals mainly with the appointment of censors from the newly formed membership whose duties were the examining and licensing of other doctors to practice in the community, to make certain that the public was protected from incompetent, untrained and unethical practitioners. The examining and licensing is now a function of the state but we must not completely abrogate this collective and individual duty. As in 1812 we are having it brought home to us that to maintain, or I might even write regain, public confidence and respect we must be vigilant and firm in maintaining our standards.

Once the doctor was one of the few educated men in the community and questions of ethics, economics, and even statesmanship were put to him. We recall that not a few of the signers of the Declaration of Independence were doctors of medicine. Although few doctors now become legislators, we are still asked, or perhaps forced partly in self-defense as part of the tax paying public, not only to prescribe for and treat many of our country's economic complaints, but also to protect the public from economic quacks and nostrums as related even indirectly to medicine. As doctors we have been taught to examine and diagnose before rushing into a course of treatment, avoiding the "do something, do anything" course of action.

The infant prepaid insurance systems, which, even in their short lives, promise to make modern medicine available to all who use ordinary self-interest and foresight, are threatened with destruction by political practitioners who offer amputation at the neck as treatment for an ingrowing toenail. With the rapidly increasing numbers of people over sixty-five, sometimes called "the elderly" by their juniors, their problems of health and happiness are not only of interest and concern to the doctor but also to the politician.

Geriatrics is coming to deal not only with prolonging useful lives and caring for the old in their ill health, but in making their retirement years useful, happy and an asset to their communities. Although this problem is in a large part an economic one, it has been turned over to medicine to cure. This involves study of cost of hospitalization, nursing homes, the various forms of insurance — prepaid, catastrophic, and comprehensive, Blue Shield-Blue Cross, our own Physicians Service, private plans, nursing costs, and doctors' bills. The next few years will require solution of the problem of making modern medicine available to the degree desired by, and economically possible for the public.

The Society's Committee on Economics will have increasing responsibility and will become one of our most important groups of advisers. It seems proper for it to include in its contemplations work done by several other committees, those on Health Insurance and on Professional Liability Insurance. Our Society cannot and does not need to resort to Madison Avenue public relations experts, but each one of us must remember that never was the public as critical of us as now. Each one of us must act accordingly to restore faith in our calling.

ALFRED L. POTTER, M.D., *President*



SAMUEL ADELSON, M.D.  
*of Newport, Rhode Island*  
*Vice President of the Rhode Island*  
*Medical Society, 1959-1960*



EARL J. MARA, M.D.  
*of Pawtucket, Rhode Island*  
*President-Elect of the Rhode Island*  
*Medical Society, 1959-1960*



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# HIGHLIGHTS FROM THE A.M.A. COUNCIL ON DRUGS

## REPORT ON TRIAMCINOLONE

*J.A.M.A.* 169:257 (January 17) 1959.

"It [triamcinolone] has an anti-inflammatory potency greater than an equal amount of prednisolone: i.e., comparable suppressive effects may usually be achieved with lower doses of triamcinolone than with prednisolone."

"Triamcinolone lacks the sodium-retaining and edema-producing effects of most other glucocorticoids. During the first several days of administration, it may cause a loss of sodium from the body; an initial mild diuretic action is frequently observed, whether the patient is frankly edematous or not. This is in contrast to the definite sodium-retaining and fluid-retaining properties of cortisone and hydrocortisone and to a much lesser extent with prednisone and prednisolone."

"Except in exceedingly large doses, triamcinolone apparently has no consistent effect on potassium excretion. Hence, neither sodium restriction nor potassium supplementation is ordinarily required during therapy with this agent."

"As with other glucocorticoids, the long-term administration of triamcinolone results in definite catabolic effects, as indicated by impairment of carbohydrate utilization and negative protein and calcium balance. This catabolic effect, coupled with a lack of appetite stimulation which is apparently peculiar to triamcinolone, may produce weight loss that might be undesirable in some patients treated for long periods of time."

"...the voracious appetite, with weight gain and euphoria, characteristic of other steroids, is not seen with administration of triamcinolone."

"Triamcinolone has been used for the management of a wide variety of clinical conditions usually considered amenable to systemic steroid therapy. These have included rheumatoid arthritis and other collagen diseases, allergic and dermatological disorders, certain leukemias and malignant lymphomas, the nephrotic syndrome, pulmonary emphysema and fibrosis, acute bursitis, rheumatic fever, and certain blood dyscrasias. Although clinical experience with the drug in some of the foregoing conditions is not extensive, the many similarities in action between triamcinolone and other potent glucocorticoids would indicate a usefulness for triamcinolone akin to that of other agents of this class."



"There is some evidence that triamcinolone is more effective at a smaller dosage than are other steroids in controlling both the skin and joint lesions in psoriasis, whether or not complicated by arthropathy."

"Triamcinolone appears to compare favorably with other steroids for use in those situations in which edema and sodium retention have been complicating problems."

"It [triamcinolone] may also be the steroid of choice for patients in whom psychic stimulation, euphoria, voracious appetite, and weight gain should be avoided."

"...the drug [triamcinolone] does produce the other side effects and untoward reactions common to the glucocorticoids. At therapeutically equivalent doses, the frequency and severity of clinical manifestations of hyperadrenalism — rounding of the face, fat deposition, and hirsutism — are essentially the same. Likewise, there is little indication that the relative incidence of osteoporosis is materially decreased after the long-term use of the drug."

"Triamcinolone apparently does not cause the euphoria sometimes seen with other steroids, and the occurrence of mental depressions is uncommon."

"Current evidence suggests that the drug [triamcinolone] may not produce as high an incidence of peptic ulcer as do other steroids."

"Cutaneous erythema seems to be a side effect peculiar to triamcinolone."

"The usual contraindications and precautions of glucocorticoid therapy should be followed in the use of triamcinolone, keeping in mind that prolonged therapy with this drug will suppress the function of the patient's own adrenals by interfering with the pituitary-adrenal axis."

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## GENERAL ASSEMBLY RESOLUTION UNANIMOUSLY ADOPTED, APRIL 10, 1959

UPON THE DEATH OF DOCTOR FRANCIS V. GARSIDE, A PRACTICING PHYSICIAN  
IN PROVIDENCE FOR THE LAST THIRTY-FIVE YEARS



*Francis V. Garside, M.D.*

THE medical profession has many members but one of the most outstanding, who had dedicated himself to medicine and people, was Doctor Francis V. Garside, a practicing physician in Providence for the last thirty-five years, who died Tuesday, April 7, 1959, at the age of sixty-two years.

Colleagues and patients long have thought of him as a latter day "Dr. Christian." His office was crowded with men and women who at times waited four or five hours to receive his mixture of kindly understanding and advice. He was one of the physicians who was never concerned about fees because patients often gave him what they thought they could afford and he was said never to have inquired closely about when the rest of the payment would be forthcoming. Medicine was his business and his hobby and he never thought of himself.

Astonishing as it may seem, another hobby of his was baseball.

Doctor Garside was born December 27, 1896,

was graduated from Classical High School. After attending Brown University, he was graduated from the Harvard Medical School in 1922. He had several interim appointments.

Doctor Garside was on the staff of Rhode Island Hospital and St. Joseph's Hospital. He became assistant gynecologist at St. Joseph's Hospital and recently was a member of the active surgical service at Our Lady of Fatima Hospital.

He had been a member of the State Board of Examiners for Medicine since 1954. He was also associated with Roger Williams General Hospital and the Charles V. Chapin Hospital. He was a member of the International College of Surgeons and the American Medical Society, as well as the Providence Medical Society.

Doctor Garside was a member of the Sons of Irish Kings, the Friendly Sons of St. Patrick, the Clover Club of Boston and the Holy Name Society of St. Sebastian's Church; now, therefore, be it

*RESOLVED*, That this general assembly, perhaps inordinately absorbed with material matters, does not realize the devotion to special duty such as Doctor Francis V. Garside gave, expresses its appreciation of his many years of dedication to his profession and extends to his widow and family its regret that his services have terminated, directing the Secretary of State to transmit to them a duly certified copy of this resolution.

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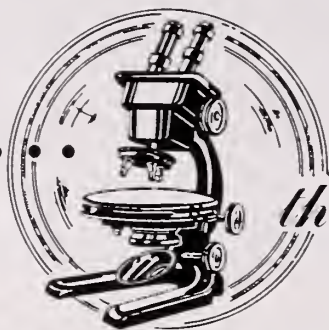
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### ***New England Health Institute at Providence, June 17-18***

The twenty-fifth annual New England Health Institute, with the Rhode Island State Department of Health as host, will be held Wednesday, June 17, and Thursday, June 18, at Providence College. Theme of the Institute will be *Changing Times and the Challenge to Health*.

Speakers already listed to address the Institute include Dr. Francis Horn, president of the University of Rhode Island; Professor William Steward, director of sales institute, Northeastern University, and Dr. A. L. Chapman, Assistant Surgeon-General of the United States Public Health Service.

### ***Rhode Island Health Insurance Benefits Reach New High in 1958***

Benefit payments by insurance companies to the people of Rhode Island who are covered by health insurance policies reached a new high during 1958, the Health Insurance Institute reported recently.

In the period from January 1 through December 31, 1958, said the Institute, an estimated 4.5 million dollars was paid out to help cover the cost of hospital and doctor bills, and to replace income lost through sickness or disability. This represents an 8.2% gain over the 1957 figure of 4.1 million dollars, and is based upon reports from insurance companies doing business in the state.

The rise in benefit payments in Rhode Island was reflected in the figures for the nation as a whole, the Institute noted. Persons protected against the expenses of hospital and medical care and treatment received a total of more than 2.6 billion dollars in benefits from their insurance company policies in 1958, up 8.3% over the previous year's high of 2.4 billion dollars.

By the end of the year, an estimated 70 million persons were covered by health cost policies bought from insurance companies, more than all other types of voluntary health plans combined.

### ***R. I. Tuberculosis Association Aids Medical Schools***

A \$1,000 appropriation to help finance special courses in tuberculosis at three Boston medical schools has been voted by the Rhode Island Tuberculosis and Health Association.

The grant will go to provide instruction for third-year medical students at Harvard, Boston University and Tufts and is part of the association's medical education program financed through the annual Christmas Seal Sale.

Mr. Harry L. Gardner, president, said that the association voted the fund because there is no medical school in the state, and that at present there are thirty-eight Rhode Islanders studying at one or another of the three Boston institutions. He said that American Medical Association figures show that of the state's 1035 physicians, 381 were trained in the Massachusetts schools.

He said that following World War II, tuberculosis courses were dropped from the curricula. The need to reinstate TB study led to establishment of a course at Harvard in 1953, under sponsorship of the Middlesex County Health Association. Its success resulted in extension of the study to other schools, financed by contributions from the Massachusetts TB associations and administered by the Massachusetts Tuberculosis and Health League.

A \$12,000 fund is needed annually for the course, and the Rhode Island association is the first to respond to the Massachusetts League's appeal to all other New England states for support.

### ***Community Information Service Established***

The *Information Service*—UNion 1-2277—of the Rhode Island Council of Community Services is now in operation under the direction of Miss A. Gloria Carbone. The new division lists its scope of activity as follows:

AN OUTREACHING SERVICE to bring together persons in need and the community service available . . . with particular concern for the chronically ill and aging

*continued on page 344*



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## THROUGH THE MICROSCOPE

*continued from page 342*

ACCURATE INFORMATION about health, recreation, welfare and related services. . . . Anyone calling can talk over his problem with a professional consultant and be referred to the appropriate community resource

CONSULTATION to agencies seeking information for their clients and patients . . . and about referrals

PURPOSE . . . to gain new information about the problems of the aging and chronically ill and the services needed to help them.

SPONSORSHIP . . . This is a three-year project financed by a U. S. Public Health Service grant to the Rhode Island Council of Community Services, Inc., in co-operation with the Rhode Island Department of Health, and supplemented by a grant from the Rhode Island Foundation. . . . It is part of a concentrated attack on the problem of chronic illness by the Rhode Island Council of Community Services, Inc.

#### *Foreign Physicians Tax Education Council Facilities*

The number of foreign-trained physicians taking the qualifying examination of the Education Council for Foreign Medical Graduates is rapidly increasing.

Only 298 took the first examination in March 1958; 844 in September 1958; 1,772 in February 1959, and more than a thousand have already registered for the next examination Sept. 22, 1959.

The council, with offices in Evanston, Illinois, aids graduates of foreign medical schools in establishing their qualification to assume internships or residencies in United States hospitals.

In the first examination, 51 per cent of the 298 candidates won standard ECFMG certificates based on a score of 75 per cent or better. No temporary certificates were issued since the language problem was not then recognized to be as great as subsequent examinations have proven it to be.

In the second examination, 49.5 per cent of the 844 candidates won standard ECFMG certificates. Another 26.8 per cent won temporary two-year certificates based on scores of 70 to 74 per cent.

In the third examination, 43.4 per cent of the 1,772 candidates won standard ECFMG certificates. Another 25.5 per cent won temporary two-year certificates.

There was considerable evidence that inadequate command of English played a major role in producing failure in the qualification examination in some of the foreign examination centers. There was one center in which three out of five candidates either failed or did very poorly on the ECFMG English test, and there were two centers where ap-

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proximately half of the candidates either failed or did very poorly on the English test. In the whole group of 494 physicians taking the examination in foreign centers, 45 showed serious inadequacy in their command of English. In contrast among the 1,278 foreign trained physicians taking the English test in U. S. examining centers, none failed and only three did poorly.

Applications for the next qualifying examination Sept. 22 must be in the ECFMG offices at 1710 Orrington Avenue, Evanston, Illinois, by June 22.

### *Air-Minded Doctors Offer Services for Civil Defense*

The services of 1,500 civilian physicians who are licensed pilots will be made available to state civil defense organizations under a program sponsored by the Flying Physicians Association, Inc.

The Association with national headquarters at Tulsa, Oklahoma, is an organization of physicians who own private planes or have them available.

The Association has established a disaster committee and has volunteered its resources for use in natural disasters or civil defense emergencies. These resources, distributed throughout the nation, include in addition to the trained physician-pilots, approximately 1,500 immediately available planes, 3,000 nurses, and medical supplies.

### *Why People Resist Vaccination Efforts*

If you're wondering why horses couldn't drag some people to their doctors for polio shots, it may be because they aren't being appealed to on the right basis. California Department of Public Health conducted a survey among uninoculated citizens and found that the biggest reasons for not obtaining protection were fear and procrastination.

Fourteen per cent of the people interviewed doubted the safety of the vaccine. Forty-six per cent of the uninoculated said they were too busy or couldn't be bothered. Expense, according to the survey, was a problem to 15% of those earning under \$2,000 a year. Twenty-four per cent of the interviewees with children under six years thought their offspring were too young for the shots.

### *Athletic Injury Symposium at Kingston in August*

A two-day symposium on *The Prevention and Treatment of Athletic Injuries* will be held on Monday and Tuesday, August 17 and 18, under the joint sponsorship of the Department of Physical Education and the Health Service of the University of Rhode Island.

The symposium, the first of its kind to be held on a major scale in New England, is designed primarily for all team physicians, athletic trainers and coaches of colleges, universities and public, private and parochial secondary schools in the New England, New York and New Jersey areas.

*continued on next page*

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Doctor A. A. Savastano, Providence orthopedic surgeon, will serve as chairman of the medical section. The program will be under the direction of Professor Fred D. Tootell, director of the Department of Physical Education for Men, and Doctor S. J. P. Turco, director of the Health Service at the University.

### ***Cold Vaccine Predicted in Next Two Years***

A vaccine which will prevent from 60 to 70 per cent of all common colds will probably be available within the next twenty-four months, an expert in cold research has predicted.

"I realize that I have stuck my neck out," Doctor Thomas G. Ward, professor of virology at Notre Dame University, South Bend, Indiana, said. However, he believes that a vaccine can be developed against "an acceptable proportion of the common colds."

In an interview, reported in the April TODAY'S HEALTH, published by the American Medical Association, Doctor Ward said he does not believe that common colds will be wiped out, even with an adequate vaccine.

"People are not going to take the vaccine, just as they are not taking polio vaccine . . ." he said. "People are people and we have great difficulty in selling preventive medicine. The prevention of disease is not as glamorous or as consuming to the individual as his actual illness."

From 75 to 80 per cent of common colds are caused by a group of viruses or a group of ordinary bacteria of the streptococcus type, Doctor Ward said. Others may be allergy-symptom colds or psychosomatic.

### ***Atlantic City Began as a Doctor's Dream***

When some 15,000 physicians converge on Atlantic City in June for the American Medical Association's annual meeting, they will be arriving at a place that began as a doctor's dream of a health resort.

In 1852, when Atlantic City was called Absecon Beach, Doctor Jonathan Pitney, who had a thriving practice in the community of Absecon, saw the advantages of the beach as a health resort. At the same time, a glass manufacturer wanted a railroad to carry his wares. Between them, the two men sold businessmen in the area on the advantages of a railroad to the island.

Once the railroad was built, a real estate boom occurred. Hotels were built, the town's name changed to Atlantic City, and the "world's leading seashore resort" began.

### ***Patient Information Folders Distributed by Ames***

Capsule information on common and complex medical problems is provided directly to patients in their physicians' waiting rooms in a new series of folders introduced by Ames Company, Inc.

The series is provided in the belief that the physician, druggist and pharmaceutical industry have a mutual interest in promoting a better patient understanding of topics pertaining to medical care.

The new series will deal with such topics as the cost of prescriptions, the medical consultation, hospital costs and medical research. The capsulated information also will act as a timesaver for physicians by covering questions which may arise during office visits.

The patients' information folder is part of Ames *Cliniquick* physicians' mailer series which deals with clinical briefs for modern practice. This new feature can be detached and folded for display on the physician's waiting room table.

"Are Prescription Costs Too High?" is the theme of the first feature in the series, included in the current *Cliniquick* issue on the management of the diabetic child. The mailer has been sent to doctors across the country.

### ***Doctors' Private Offices in Community Hospitals?***

Physicians will have private offices in more non-profit community hospitals in the future predicts a new monograph published by the American Hospital Association.

The monograph, PHYSICIANS' PRIVATE OFFICES AT HOSPITALS, is the report of a research project conducted by Doctor C. Rufus Rorem, executive director of the Hospital Council of Philadelphia and supported by a research grant from the Division of Hospital and Medical Facilities, U. S. Public Health Service.

The monograph states that physicians' offices in hospitals will enable patients to use the hospital as a one-stop center and "achieve convenience and effectiveness in medical practice."

"The doctor remains at one location throughout the entire day. He may interrupt his office practice for emergencies in the hospital and he avoids the necessity of traveling to and from the hospital," it points out.

"Doctors' offices at hospitals are a logical development of specialization in medical practice," according to this report. "The doctors provide the professional knowledge and skill. The community provides the funds for buildings and diagnostic and treatment facilities."

Areas investigated for the project include the types of private offices, the legal aspects, rental rates and policies, and lease provisions.

### ***New Light on Health Problems of the Over Age 65***

"Aging people inevitably face special health problems, and most older people have health problems that bother them to some extent," Health Information Foundation reported recently.

In fact, about 85 per cent of the persons in the

over-65 age group interviewed recently in a Foundation-sponsored survey said they had had some health complaint or other illness which bothered them within the previous four weeks.

Early results of the survey were published in the Foundation's monthly statistical bulletin, *PROGRESS IN HEALTH SERVICES*. The study was made in cooperation with the National Opinion Research Center of the University of Chicago, in which a random cross-section of the U. S. population of 65 and over were interviewed at length about such items as their health, living arrangements and income.

Persons 65 and over were found to average 7.6 visits to doctors a year per capita—about two visits a year more than the average for all age groups in this country. The survey also showed that almost two out of every five older persons had not seen a doctor during the previous twelve months, and 10 per cent of the survey group hadn't been to a physician in five years or more.

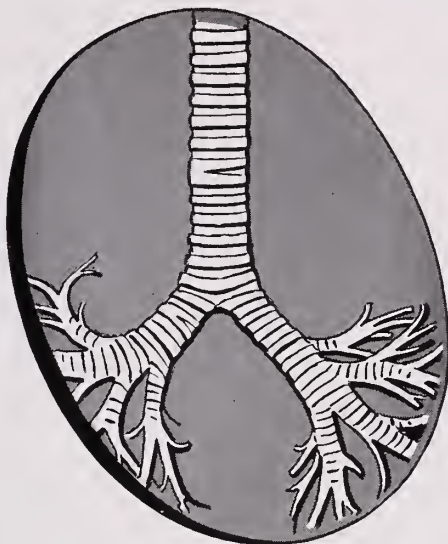
Only one out of every three persons interviewed who had a health complaint, however, had told a physician about it. "Economic factors seem to be a relatively minor element in this reluctance to see a physician," said George Bugbee, Foundation president. Even though incomes are generally lower among the older age groups, only 3 per cent of all persons 65 and older said they had delayed consulting a physician because of the cost.

Another reason why some older people fail to seek medical attention, Mr. Bugbee continued, "may be a feeling that visiting a doctor or a hospital is tantamount to acknowledging an inability to cope with the inevitable illnesses of old age."

Older persons, he conceded, "may be justified in reasoning that some sickness is inevitable. In addition, most of them remember a time, not too many years ago, when doctors and hospitals were far less effective than they are today. Modern medicine, however, often can alleviate or delay the disabilities of the later years. The proportion of people reaching advanced ages nowadays is in itself testimony to the skill of medical science. Older people need a greater awareness that the health professions can help all age groups—not simply those in the young and middle years."

Among the older persons who had visited a doctor within the four weeks before being interviewed by N.O.R.C., four out of every five were able to pay for the service, either from their own income or savings, or with the help of a relative. About 58 per cent of the persons paying for such services reported bills of under \$10.

About one fifth of the older persons receiving medical care in the four-week period had not had to pay for it, the Foundation report said. In most of these cases, the bill was met by a welfare or charitable agency, or else the doctor made no charge.



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of bronchospasm in*

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## DISTRICT MEDICAL SOCIETY MEETINGS

### NEWPORT COUNTY MEDICAL SOCIETY

The regular meeting of the Newport County Medical Society was held at the Hotel Viking on Wednesday, April 1, 1959. Doctor Charles B. Ceppi, president, presided.

The applications of Doctors Mauricio Golberg, Block Island, Rhode Island; Thomas R. Cox, pathologist, Newport Hospital, and William C. Hartnett, Jr., Tiverton, Rhode Island, for active membership in the Society were referred to the censors.

Under communications received, it was noted that the Newport County Public Health Department would have a mobile chest unit in this area for X rays of those over 20. This service was endorsed by the members. A communication from Representative John E. Fogarty regarding the Self-Employed Individual's Retirement Act of 1959 was read and discussed. It was moved to notify Senators Green and Pastore of our endorsement.

Doctor John Malone, reporting as counsellor, discussed such problems as the Hearing Clinic at the Rhode Island Hospital; the Forand Bill; the Providence telephone directory listings of specialties in

the classified section; and remarked that Newport Society members were well represented in practically all the state committees. He spoke of the trend toward Social Security for doctors in the nation and all members present unanimously approved Social Security for doctors. Doctor Malone was requested to take a poll of all the absent physicians, so that the state society would be cognizant of our feelings.

Doctor Ciarla discussed the new Blue Cross-Physicians Service Indemnity Plan. He also pointed out that the mails have been used to advertise and defraud by presenting literature that was received a few days ago and he urged that the Society condemn such advertisement.

The president then discussed bills before the State Legislature and Senate Bills No. 125 and No. 372 and House Bills No. 1353 and No. 1094. The members approved the action of the State Judiciary Committee in regard to these bills.

The meeting adjourned at 8:30 P.M.

Respectfully submitted,

EDWARD ZAMIL, M.D., *Acting Secretary*

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9B's NEARLY PUT ME  
ON THE SHELF...

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**AND THE PAIN  
WENT AWAY FAST**



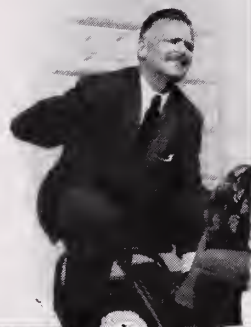
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## MEDICARE REGULATIONS

### Statements Required of Physicians to Substantiate Claims

\* \* \*

#### — Acute Emotional Disorders Complicating Pregnancy

##### *Statements Required of Physicians to Substantiate Claims*

1. A number of inquiries have come to the attention of this office concerning the extent to which a Fiscal Administrator should go in verifying physicians' statements made on claims in connection with covering emergencies and covering acute surgical conditions.

2. It has always been the policy of this office to rely upon the judgment and integrity of the cognizant medical authority (charge physician) in substantiating claims. In furtherance of this policy when the cognizant medical authority (charge physician) indicates on the claim form, or attachment thereto, that an acute or emergent medical or surgical condition existed which required prompt treatment in a hospital without delay, and if the care is furnished in compliance with the conditions outlined in the claim, *if otherwise complete, is payable without further reference to this office.* It is emphasized, that the acute or emergent condition mentioned above must be of a medical or surgical nature—not socio-economic.

3. The basic statement of the physician supporting a claim should be concise and should not be so qualified as to raise doubt as to the meaning of the basic statement itself. The types of statements required in support of claims involving emergencies and acute surgical conditions are described below:

a. *Statement Required in the Case of an Emergency Requiring Hospitalization*—The statement required in cases covered in paragraph 5a(1) of ODMC Letter No. 16-58 is: "The case was a *bona fide* acute emergency."

b. *Statement Required in Cases Involving Acute Surgical Conditions*—The diagnosis, on the claim form, or any separate statement or certification attached thereto, submitted by the charge physician, which *clearly states* that the conditions covered prevailed, may be accepted. *For guidance only*, an acceptable certification is set forth below:

"An acute condition existed requiring hospitalization, without delay, for the purpose of carrying out surgery at the earliest practicable time."

4. Guidance was furnished previously on cases involving *acute medical conditions*. Set forth below, for ready reference, is paragraph 8b, ODMC Let-

ter No. 16-58:

"The provisions of the Joint Directive pertaining to the treatment of acute medical conditions remain unchanged. However, in accordance with ODMC Letter No. 25-57, dated 24 December 1957, the admission of patients not acutely ill for diagnostic surveys will not be payable."

5. It is expected that a physician's diagnosis on the claim form or any separate statement or certification substantiating either an emergency, acute surgical condition, or acute medical condition, will be consistent with the clinical facts in the case.

6. In those unusual instances where the Fiscal Administrator has reason to believe that an inconsistency exists, the case, together with copies of pertinent hospital medical records, should be referred to this office for consideration.

7. Assistance to Hospitals—Physicians are urgently requested to assist hospitals by furnishing to them information and statements necessary to properly substantiate hospital claims. The necessity for physicians' assistance must again be emphasized. Adjudication by the different Fiscal Administrators can best be achieved when the information supporting the separate claims (hospital and physician) is consistent.

##### *Acute Emotional Disorders Complicating Pregnancy*

1. This letter supersedes any instructions previously issued concerning this subject which may be in conflict with the contents as stated herein for Acute Emotional Disorders Complicating Maternity Care.

2. Increasing evidence has come to the attention of the Office for Dependents' Medical Care indicating a need for clarification of the extent to which the Government will pay in the case of *eligible dependents who develop acute emotional disorders complicating pregnancy or constituting postpartum psychosis occurring within the authorized six (6) weeks postpartum period.* This clarification is in consonance with the provisions of the Program relating to complete obstetrical and maternity services.

3. Due to the separate contract arrangements relating to payment of hospital and physician



charges, this subject requires separate consideration for the procedures relating to payment of the care identified in the preceding paragraph.

#### 4. CARE AUTHORIZED

##### a. Antepartum Period

(1) Hospital Services: In-hospital care may be authorized for limited periods when such cases constitute an actual complication jeopardizing pregnancy. Requests for payment of in-hospital care of the acute phase of the emotional disorder arising during pregnancy must be accompanied by certificate(s) signed by the attending physician and/or the physician providing psychiatric skills. This certification of clinical facts must be in sufficient detail to establish the nature of the acute phase of the emotional disorder which is considered to jeopardize the pregnancy. Payment for the acute phase of the emotional disorder will be limited solely to services required for its management.

(2) Physician Services: To preclude delays in payment and prolonged correspondence, requests for payment of physician services (DA Form 1863) related to in-hospital management of the case submitted by the attending physician and/or the physician providing psychiatric skills must show the identical certification as required by paragraph 4a(1), above.

##### b. Postpartum Period

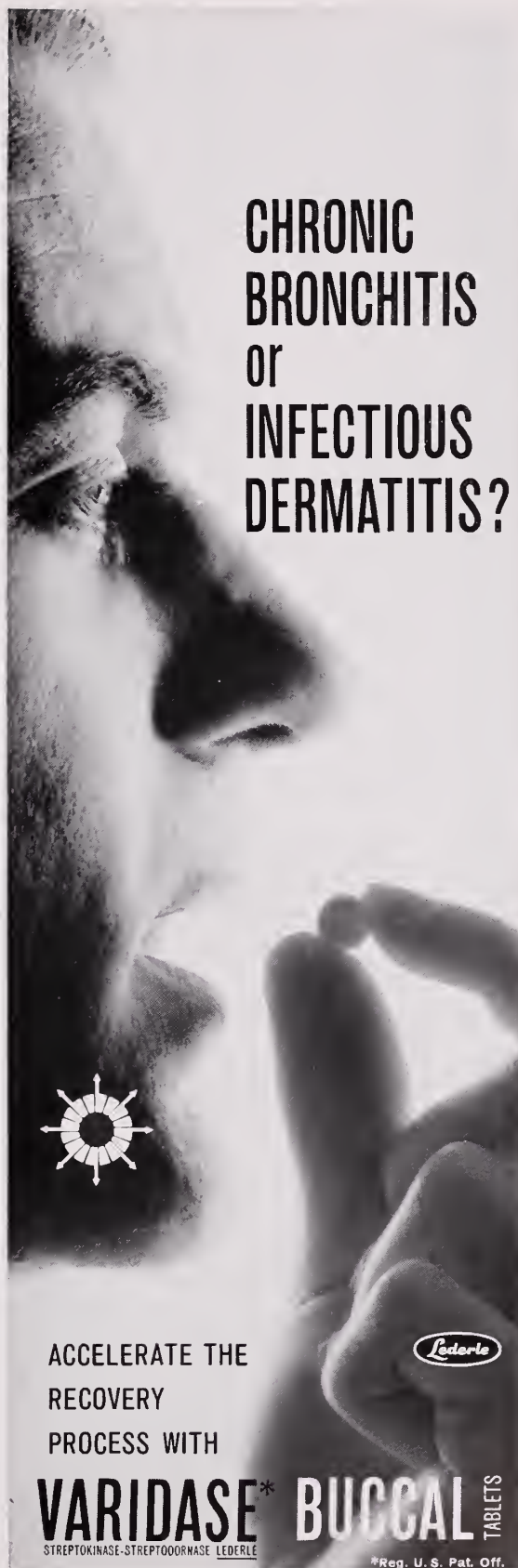
(1) Hospital Services: To be payable under the Dependents' Medical Care Program, the admission for in-hospital care of postpartum psychosis must have occurred during the authorized six (6) weeks postpartum period. The maximum Government liability will be limited to the management of the acute phase of the postpartum psychosis. For this service to be payable, claims must be accompanied by certificate(s) of the clinical facts signed by the attending physician and/or the physician providing psychiatric skills. This certification must indicate that an acute phase of the postpartum psychosis existed at the time of admission to the hospital and that the acute phase extended through the entire period covered by the claim submitted.

(2) Physician Services: Requests for payment of physician services related to in-hospital management of the case identified in paragraph 4b(1), above, must be accompanied by the same certification as indicated in that paragraph. This certification must accompany the DA Form 1863 (Claim) submitted by the attending physician and/or the physician providing psychiatric skills.


#### 5. CARE NOT AUTHORIZED

a. *Pseudocyesis* or its management as this condition has never constituted authorized care under the Dependents' Medical Care Program.

*concluded on next page*



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or  
INFECTIOUS  
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- b. *Outpatient care* for acute emotional disorders.

\* \* \*

*Statement of Attending Physician With  
Reference to 2d Trimester of Pregnancy*

*On or Before 1 October 1958*

1. A number of inquiries have been received from Medicare Contractors as to whether this office contemplates establishing a cut-off date for accepting the statement of the attending physician that the maternity patient, residing with sponsor, had reached the second trimester on or before 1 October 1958.

2. The physician's statement is acceptable in those instances where the delivery is performed on or before 30 April 1959. This position was reached after careful consideration of the maximum normal period of gestation, a reasonable period of time to allow for unusual cases, and the information likely to be available to the physician when he made the determination that the patient had reached her second trimester of pregnancy on or before 1 October 1958.

3. Where delivery is performed after 30 April 1959, a PERMIT will be required when the dependent patient is residing with sponsor. There may be a few cases, certified to have reached the second trimester on or before 1 October 1958, which the physician believes to be so unusual as to warrant special consideration. In those instances where the physician requests that his claim be reconsidered, the fiscal administrator should forward, to this office, the DA Form 1863, the physician's statement, and any other pertinent information supporting the claim.

---

**Wednesday . . . June 24**

**GOLF TOURNAMENT**

**and**

**ANNUAL DINNER**

**Providence Medical**

**Association**

**FETAL DEATHS (*Stillbirths*)**

The Rhode Island State Department of Health has adopted the following new regulations, effective April 1, 1959:

*Definition of Fetal Death*

"Fetal death is death prior to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such separation, the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles."

The above definition was recommended for adoption in May, 1950, by the World Health Organization. This definition has been adopted in the United States as the nationally recommended standard. The term "Fetal Death" was defined on an all-inclusive basis to end confusion arising from the variety of usages of such terms as stillbirth, abortion, miscarriage and others.

It is requested that all fetal deaths, irrespective of the number of weeks of utero gestation, be reported on the fetal death certificate (red "stillbirth" form). Fetal deaths of less than twenty weeks' gestation do not require burial. Reports should be appropriately marked and sent directly to the State Department of Health within seventy-two hours after such delivery.

Each fetal death which occurs in this state after a gestation period of twenty completed weeks or more must be registered with the local registrar of the district in which delivery occurred. If the number of weeks gestation is uncertain other criteria are: 1.) weight of 400 grams or more, or 2.) a crown-rump measurement of at least 16.5 cm.

The funeral director or person acting as such who first assumes custody of a dead body or fetus shall obtain a burial-transit permit prior to final disposition or removal from the state of the body or fetus which has attained twenty weeks' gestation. Such permit shall be issued by the local registrar of the district where the death occurred when a certificate of fetal death has been filed.

The requirements for filing a fetal death certificate for a fetus which has attained twenty weeks' gestation are the same as those for filing a death certificate. When no physician was in attendance, the certificate must be signed by the medical examiner.

---

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JUNE, 1959

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**bibliography:** (1) Carter, S. M.: *M. Clin. North America*: 315 (March) 1953. (2) Chao, D. H.: *Ibid.*, p. 465. (3) Gilman, L. S., & Gilman, A.: *The Pharmacological Basis of Therapeutics*, ed. 2, New York, MacMillan Company, 1958, p. 187. (4) Davidson, D. T., Jr., in Conn, H. E.: *Current Therapy 1958*, Philadelphia, W. B. Saunders Company, 1958, p. 568. (5) Zimmerman, F. T.: *New York J. Med.* 55:2338, 1955. (6) French, E. G.; Rey-Bellet, J., & J. W. G.: *New England J. Med.* 258:892 (May 1) 1958.





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\*1. Borrus, J. C.: J.A.M.A. 157:158, April 30, 1955. 2. Sellin, S.: J.A.M.A. 157:1594, April 30, 1955. 3. Lemere, F.: Southwest Med. 198, Oct. 1955. 4. Benoit, B. and Locutti, C.: Lav. neuro-psychiat. 18:693, 1955. 5. Sellin, S.: J. Clin. Exper. Psych. 17:7, March 1956. 6. Berglund, M., Blumenthal, B., and Lorch, P.: Svenska läk. 53:3362, Dec. 1956. 7. Mel, H. A., Wood, J. A., and Dixon, H. H.: New York Acad. Sci. 67:780, May 9, 1957. 8. Hollister, E., Elkins, H., Hiler, E. G. and St. Pierre, J.: Ann. New York Acad. Sci. 67:789, May 9, 1957. 9. G. J.: Russ. med. 34:233, July-Aug. 1957. 10. Li, R. et al.: J. Pediat. 52:27, Aug. 1957. 11. Wiklund, P.: Anaes-thesist 1947, Aug. 1957. 12. Tucker, W. I.: South. J. 50:1111, Sept. 1957. 13. Rolandi, A.: Attual. ostet. 3(6):49, Nov.-Dec. 1957. 14. Becker, W.: Klin. Monats. 1. August 1958:224, 1958. 15. Nebianco, G. and Ceroni, T.: Oto-rh. Laryng. ital. 26(2):143, 1958. 16. Ma, G.: Minerva 19:1914, 1958. 17. Russo, R. and Atti, F.: Act. Neurol. 3(1):36, 1958. 18. Gazz. med. ital. 104:49, Feb. 1958. 19. Castur, R.: J. Indian M. Assoc. 13, Feb. 1958. 20. St. W.: Therap. 97:66, Feb. 1958. 21. B.: Lyon méd. 1958, March 2, 1958. 22.iglia, C.: Minerva 10:218, March 15, 1958. 23. Glander, H. S.: J. Cardiol. 1:395, March 1958. 24. McClen: Arch. Pediat. 75:101, March 1958. 25. Sprauer, V. J.: Internat. Rec. Med. CP Clinics 171:1, 1958. 26. Binson, R.: Robinson, H. M., Jr.: South. M. J. 51:679, April 1958. 27. S. and Peller, L.: Neurol. Med. 52:1285, April 15, 1958. 28. Bouquerel, J., Naviau and: Ann. méd. psychol. 118:1, 1958. 29. Reboul, E., Reboul, M. and Dorgeville, C.: Maroc 37:784, July 1958. 30. B.: Lyon méd. 200:885, Nov. 1958. 31. Lamphier, T. A.: Maryland M. 7:627, Nov. 1958. 32. Leuka: Med. Klin. 53:2113, Dec. 1958.

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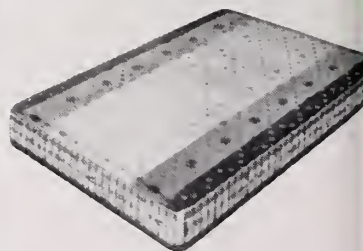
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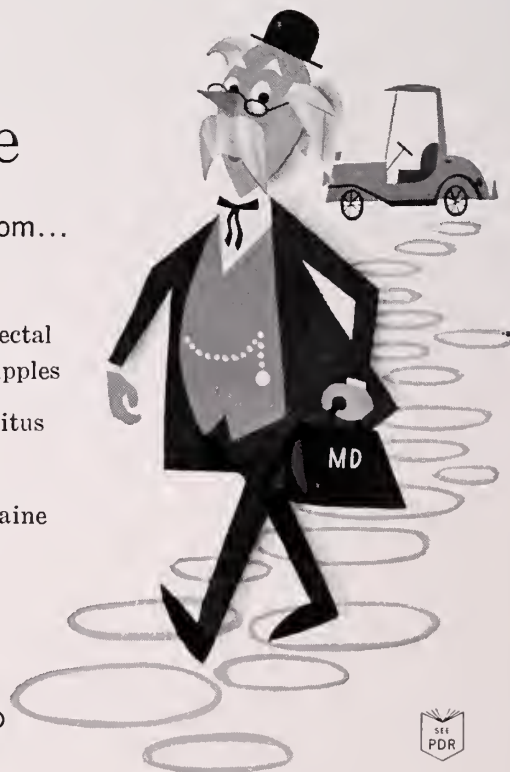


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*References:* 1. Sheldon, J. M.: Postgrad. Med. **14**:165 (Dec.) 1953. 2. Hubbard, T. F. and Berger, A. J.: Annals Allergy p. 350 (May-June) 1950. 3. Kline, B. S.: J. Allergy **19**:19 (Jan.) 1918. 4. Goodman, L. S. and Gilman, A.: Pharmacol. Basis Ther., Macmillan, New York, 1956, p. 532. 5. Fabricant, N. D.: E.P.N.T. Monthly **37**:460 (July) 1958. 6. Lhotka, F. M.: Illinois M.J. **112**:259 (Dec.) 1957. 7. Farmer, D. F.: Clin. Med. **5**:1183 (Sept.) 1958.

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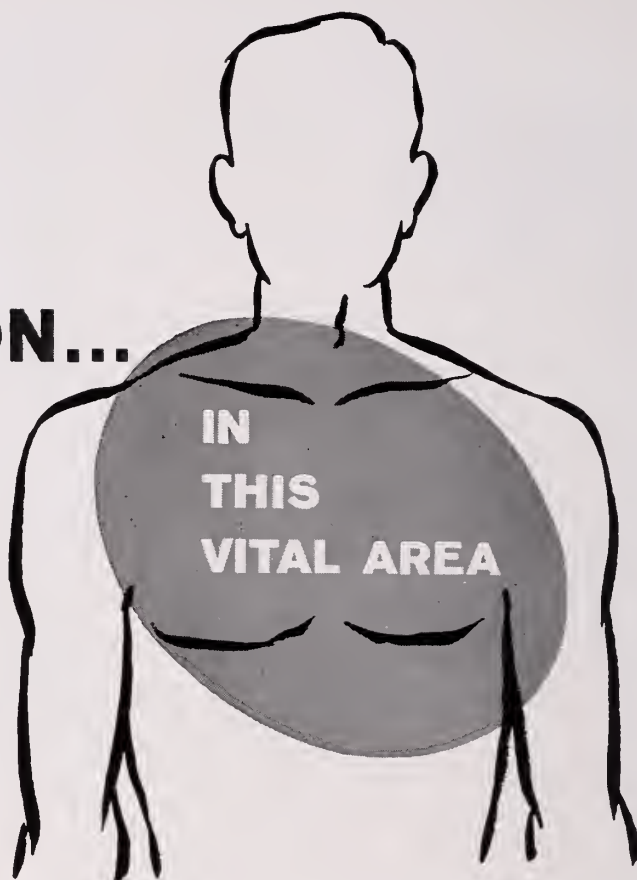
running noses



and open stuffed noses orally



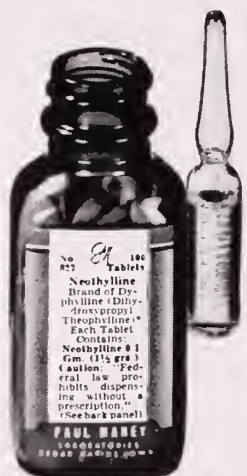
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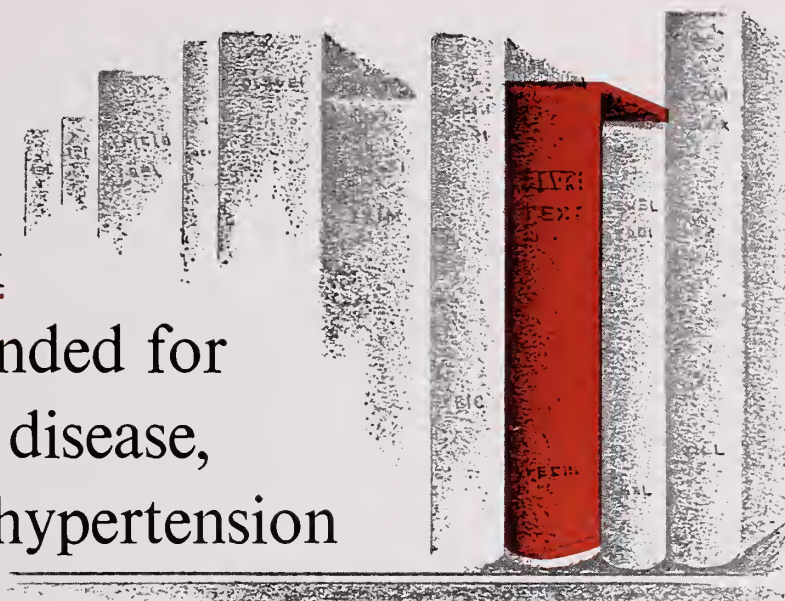
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- \*Paul Dudley White, "Heart Disease" 1951 (Macmillan) page 480;
- William D. Straud, "Current Therapy," 1955 (W. B. Saunders) page 102;
- Cecil & Loeb's Textbook of Medicine, 1955 (W. B. Saunders) page 1,326;
- Wilson & Gisvold, "Textbook of Organic Medicinal and Pharmaceutical Chemistry," 1956 (Lippincott) page 262;
- Goodman & Gilman, "The Pharmacological Basis of Therapeutics," 1941 (The Macmillan Co.) page 281;
- Albrecht, "Modern Management in Clinical Medicine," 1946 (Williams & Wilkins) page 254;
- Friedberg, "Diseases of the Heart," 1956 (Saunders) page 285;
- Walter Modell, "Drugs of Choice," 1958-1959 (C. V. Mosby) pages 100, 475, 615.

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1. Kety, S. S.: A medical regimen for benign rectal disorders, *GP* 10:75, Nov., 1954.

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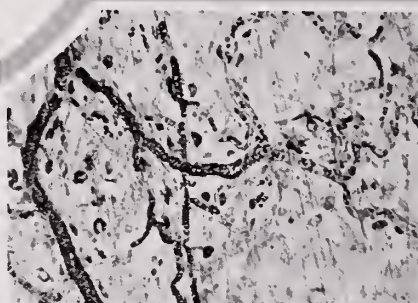
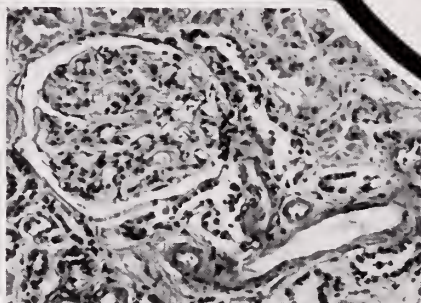
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**References:** 1. Moyer, J. H., and others: *Am. J. Cardiol.*, 3:113 (Jan.) 1959. • 2. Bodi, T., and others: To be published, *Am. J. Cardiol.*, (April) 1959. • 3. Fuchs, M., and others: *Monographs on Therapy*, 4:43 (April) 1959. • 4. Montero, A. C.; Rochelle, J. B., III, and Ford, R. V.: To be published. • 5. Rochelle, J. B., III; Montero, A. C., and Ford, R. V.: To be published.

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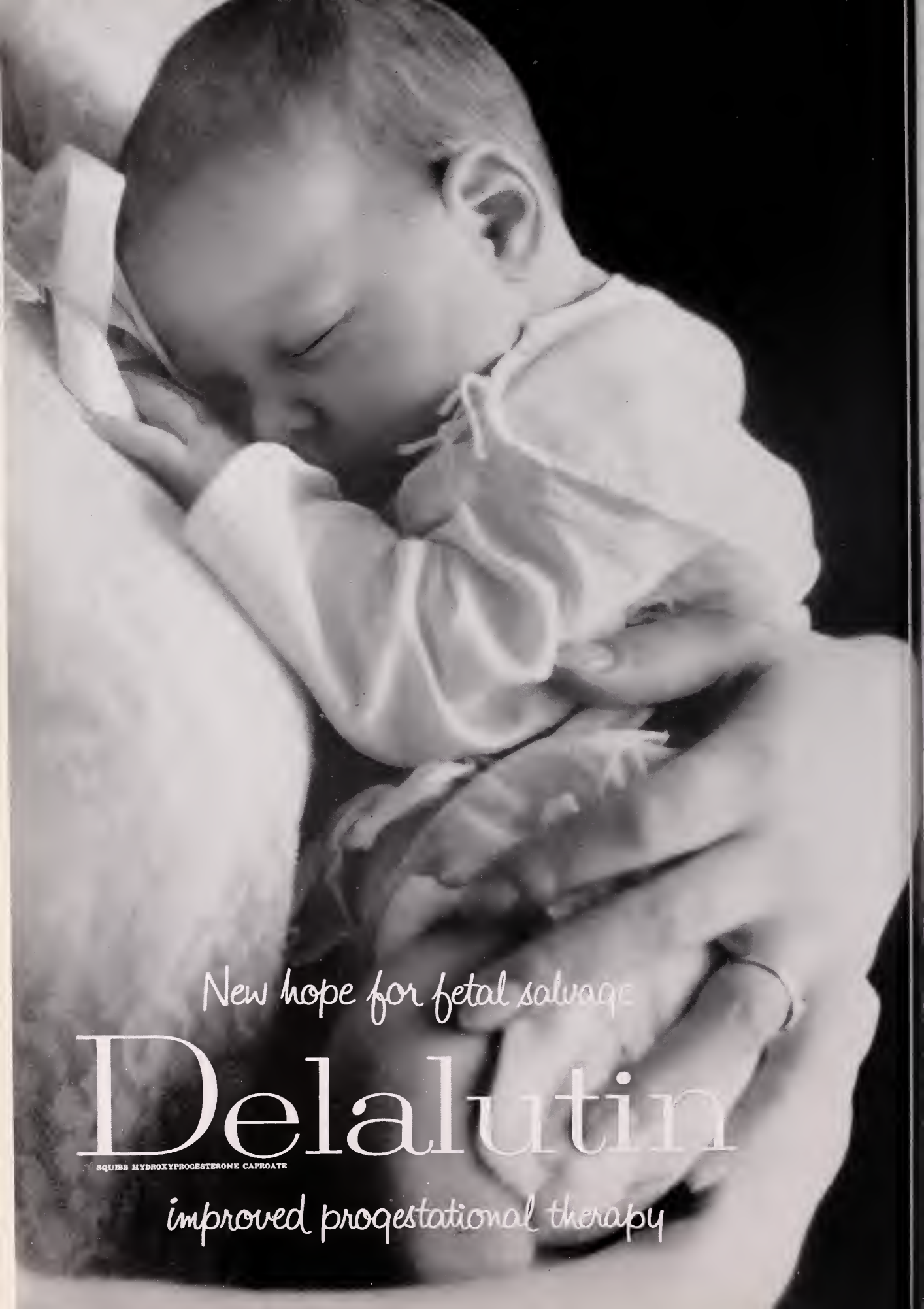
1. Editorial: *New England J. Med.* 258:48, 1958.

2. Vinnicombe, J.: *Antibiotic Med. & Clin. Ther.* 5:474, 1958.

3. Sheth, U. K., et al.: *Ibid.*, p. 604, 1958.

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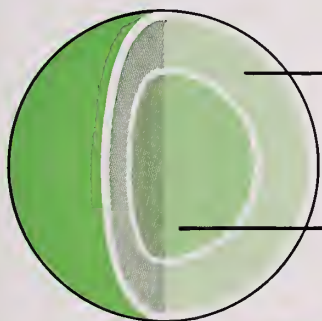
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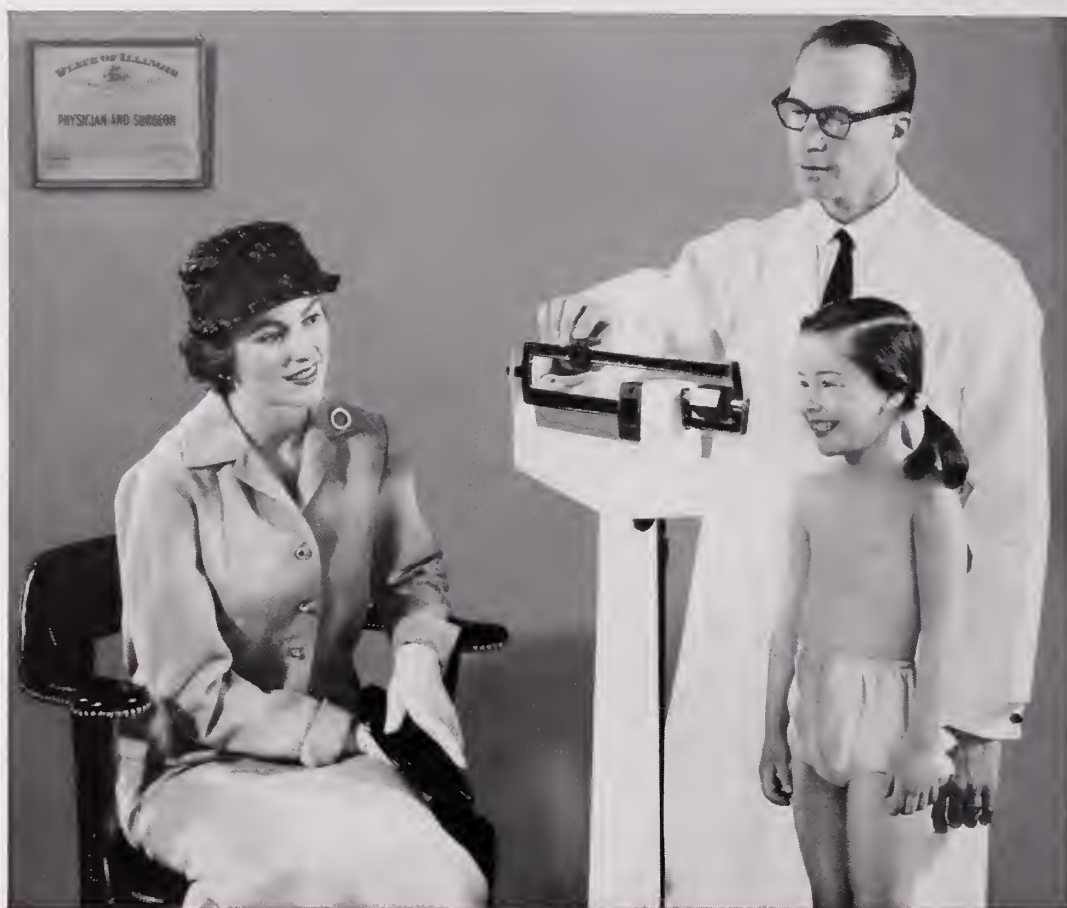
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\*Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.



## THE EIGHTEENTH CHARLES VALUE CHAPIN ORATION CHAPIN AND MODERN EPIDEMIOLOGY\*

JOHN R. PAUL, M.D.

---

The Author. *John R. Paul, M.D., of New Haven, Connecticut. Professor of Preventive Medicine, Yale University Medical School.*

---

IT IS CUSTOMARY on occasions of this kind for the speaker to express his appreciation of the honor involved. I hope that my reference to this will not sound perfunctory, for I am very much aware of this honor which is more than a personal one. It is an honor both to me and to the university I represent.

My knowledge of the man, whom we honor tonight, comes from a study of his portrait and his writings. The former gives us the picture of an earnest, almost wistful man with academic idealism, written on his face; his writings, which span a period of fifty years, give us a record of his thoughtful opinions which carry with them the convictions of a man—confident that what he was doing was right. Regardless as to what his contemporaries might have said a generation ago about Doctor Chapin's dull columns of figures, bio-statisticians have certainly leaned heavily on them ever since and two generations of students of epidemiology have been brought up on them. I have enrolled myself among these students. It is for this kind of education that I also wish to express my appreciation this evening.

In an appraisal of Doctor Chapin's life and work, particularly as an epidemiologist, I have drawn upon the opinion of my senior colleague, the late Professor Charles-Edward A. Winslow;<sup>1</sup> as well as the late Doctor Haven Emerson. The latter stated in the foreword of a book which contains some of Doctor Chapin's collected papers, that "the truest recognition which we can give to his leadership is to search for the answers of the questions he has phrased."<sup>2</sup> This will be the text of my talk this evening.

First, in order to consider questions, that Doctor

Chapin "has phrased," we must project ourselves back into the environment of that half century in which he worked,—from 1880 until 1930. This was the period marking the beginnings of the sanitary age. The militant reformers who promoted preventive medicine and hygiene at this time were in every sense of the word true crusaders, dedicated to the cause of pure water, clean food and milk for America: W. T. Sedgwick of Boston, Hermann Biggs and Haven Emerson of New York, Doctor C.-E. A. Winslow of New Haven and no doubt, many others. These pioneers of public health strove through health education and other various ways to stamp out infectious diseases by improving environmental sanitation, by applying the new science of bacteriology. The medical profession at that time was dragging its feet as far as pushing this cause. Politicians also took a dim view of these reforms and it was a situation which badly needed champions, if there was to be any change. Like the British leaders in London,—Chadwick and Simon before them, Sedgwick and his followers fought against odds, for improvements in the slums, and for social welfare in an age which regarded such efforts as local benevolences rather than the normal and proper responsibilities of both laymen and physicians. Before this period of social awakening, George Bernard Shaw's epigram that, "The trouble with the poor—is poverty" would have seemed to be a good enough description for the whole grimy business.

That it would have required statisticians to tip the balance in favor of such reforms may seem strange, but here was an instance where facts turned out to be more convincing than words. The facts were, that the prevalence of disease and the death rates were higher, often far higher in the slums than in other parts of the city. To prove this, year after year such statistics were shown to those in control of municipal conditions until the city officials simply had to do something about it. Chapin, no doubt, was one who provided these facts from his carefully compiled lists of vital statistics about disease in this city of Providence, and few

*continued on next page*

---

\*Delivered at the 148th Annual Meeting of the Rhode Island Medical Society, at Providence, Rhode Island, May 12, 1959.

people had a better appreciation of the impact of good and bad environments on the health of the community than did he. He must have known this city as a country pastor knows his flock.

And now I wish to come quickly to the point of my remarks which concern Doctor Chapin's role, not as a sanitarian which he had to be most of his life, but as a *modern* epidemiologist, a man well ahead of his time. Many of his papers fail to reflect this fact. Instead they illustrate the contemporary concept of an epidemiologist which in those days called for a man whose first duty was to stamp out infectious disease much as a preacher might try to stamp out sin. Today the epidemiologist has at least two functions: first to study the circumstances under which disease occurs; and second perhaps to do something about the situation, or at least to get someone else to do this for him. One can contrast these functions with those of a fireman and his academic counterpart. Although the fireman's duty may be to put out fires, his academic counterpart is one who studies conditions within a house or a city which will lead to a better understanding as to how fires develop and how they get out of control. Although Chapin was a good "fireman" and served as the Superintendent of Health of the City of Providence for the incredibly long period of 48 years, he also found time to devote to the second and more academic function, namely, to visualize what his figures meant. As an example, one of his last papers is titled, *Science of Epidemic Diseases*.<sup>3</sup> Some may question whether epidemiology has even yet achieved the stature of a *science*,—contrasting it with meteorology and pointing out that both subjects deal with fairly nebulous things. But it has the hope of a science today and its methods are fairly accurate which Chapin had begun to use as early as 1913, and again in 1926, when we find him writing on the *variation* of types of infectious diseases. He was among the first to note that scarlet fever used to be a severe and common disease and during his lifetime he saw it becoming less severe and less common. Why was that? This was long before the days of antibiotics. In other words, almost fifty years ago, he was pondering on questions as to what makes each generation have its own diseases, as well as its own methods of handling them. Thus he says, in his Sedgwick Memorial Lecture,—“it is hoped that someone will give further study to the problem, for its solution seems to me to be a matter of great moment.”<sup>4</sup>

I too wish to speak of this point, namely the *variation* in disease, because it is with the changing pattern of diseases that modern epidemiology is now concerned. Today the subject has progressed and the concept of this “science” has broadened to include all kinds of disease (not infectious disease alone). Heart disease, cancer, drug addiction and

benzol poisoning, all have their epidemiologies which are concerned with various sets of predisposing circumstances, and we all know that circumstances are wont to change. This epidemiologic concept, namely to measure and study these circumstances which predispose to disease, whether they be microbiological, immunological—even political or religious, has become an integral part of the principles and practice of medicine today.\* It is a field no longer dominated by or limited to public health officials or public health professors for it is a growing subject now taught in medical schools. *Clinical epidemiology*<sup>5</sup> has now come into its own too, and we find it in medical textbook descriptions of a disease today. It is a field now in which doctors of all kinds have much to contribute and much to learn, as has been well exemplified in Dr. J. N. Morris' small book, *The Uses of Epidemiology*.<sup>6</sup> As an example of the physician's and surgeon's interest in this subject today we see Doctor Paul Dudley White being deeply concerned with the epidemiology of heart disease and its prevalence in different places.<sup>7</sup> We see the late Doctor Evarts Graham, a well-known surgeon, studying the epidemiology of cancer of the lung and we see Doctor Joslin studying the epidemiology of diabetes.

But granted that epidemiology is a growing subject today, let us return to the changing picture of disease. In the United States the diseases of the twentieth century have shifted almost with each decade, just as the ways of life have shifted during the last half century. In Figure 1, we see the experience of fifty years in the U.S.A., indicating that the infectious diseases which were largely responsible for killing people in 1900 have now been replaced by quite another set. The change, whether for the better or worse, has by no means come about entirely through the efforts of the medical and public health profession, although they have had a major part in it, but others have had a hand in it too. Building contractors have not been slow to recognize that comfort and longevity are desirable commodities. Plumbers and manufacturers of iceboxes have contributed their share. Their combined efforts, when added up, have brought about a reduction in the hazards of early life, most of which were due to acute or chronic infectious disease. To a certain extent modern North American living now calls for surroundings, habits and tranquilizing drugs which would have seemed strange, artificial and perhaps luxurious to our great-grandparents. Sanitation, refrigeration of food, central heating, the automobile, antibiotics are all factors of epidemiologic significance which have exerted an impact on the

\*Various other names have been proposed for this kind of approach: *social pathology*, *population pathology*, *social medicine*, but the descriptive term *epidemiology* seems the most apt.



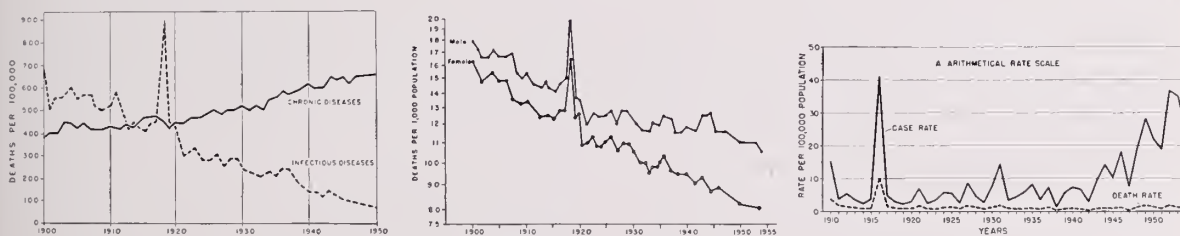
illnesses we acquire and the members of the population who are here to acquire them. We should expect then, as the hazards to early life and threats to premature death are curtailed, the ever increasing number of people arriving at age 65 will create more and more opportunities for them to acquire the *diseases of old age*, and more opportunities, if you will, for the geriatrist. From an epidemiologic point of view this is an example of man's reactions to a changing environment and new ways of life. It makes us realize that if man is successful in conquering certain diseases, particularly of early life, this in itself is not the end of the struggle—not at all. For in the face of a decline in infectious disease as measured by death rates a host of new problems is appearing and new challenges to face. One can hardly look at this shifting scene without wondering whether it is good or bad—what it will add up to—tomorrow. It seems to represent man's struggle to survive according to his own interpretations as to what is good for mankind—and for himself. Doctor Rene Dubos of the Rockefeller Institute perhaps thinks that we don't recognize the importance of the element of struggle in this picture—he has gone so far as to say in his recent book<sup>8</sup> "complete freedom from disease is almost incompatible with the process of living."

At least the situation should encourage efforts to develop preventive measures designed to deal with the diseases of middle life or old age, although so far the record is not so good here. In fact the death rate among adults is not declining in a spectacular fashion (Figure 2), female mortality has kept a downward course, but the decline in male mortality is much less. As a reflection of this it has been claimed that the average married woman in this country may expect to look forward to ten years of widowhood. This results from the fact that there are certain common diseases which attack men in middle age which, in this country, are *not* declining. They include:—duodenal ulcer,—carcinoma of the

lung, and coronary occlusion. The first of these is responsible mainly for ill health, the next two are killers, and not only are they not going down but they are on the increase.

The problem here is, that not only are these diseases not being conquered or controlled, at least as far as the male sex is concerned, but, as we watch them on the increase, one is faced with the fact that they seem to be so closely tied with modern living, that they are almost actual *products* of our age. Perhaps we even deserve the blame for having created them. You all know the story of attempts to incriminate rich diets and lack of continued physical activity, especially for the business executive, as contributing factors, although by no means proven ones, for the creation of vascular disease. Doctor Morris' studies on the incidence of angina pectoris and coronary disease in London bus drivers who sit, as opposed to bus conductors who scramble up and down an iron staircase, is a provocative example of clinical epidemiologic research here. The researches on excessive cigarette smoking as a factor in the genesis of carcinoma of the lung is another example. These then may be examples of diseases of our own making, and it is the prime duty of the clinical epidemiologist today to observe and weigh the evidence and consider the extent to which ways of living, which today we regard as acceptable, may not be all right; and, indeed may be as far off the beam as were living conditions in the seventeenth century in London where cholera and plague flourished. The Londoner's problems of that day were dirt, contaminated water supply, rats, lice and so forth, but apparently they were not aware that anything was wrong. Our problems—and our circumstances may be those of too much indulgence of creature comforts. We probably smoke too much, the students of alcoholism insist that we drink too much, and I suspect they are correct, although it is doubtful whether this is unique to this particular age. We certainly eat too

*continued on next page*



FIGURES 1, 2, AND 3

Figure 1. Deaths per 100,000 population from chronic diseases and from acute infectious diseases in the United States, 1900 to 1950. From Paul, J. R.: *Clinical Epidemiology*. Univ. Chicago Press, 1958. (Basic data from The National Office of Vital Statistics.)

Figure 2. Sex-specific mortality rates, United States, 1900-1954. The male rates are declining more slowly than the female. From Paul, J. R.: *Clinical Epidemiology*. Univ. Chicago Press, 1958. (Basic data from The Health Information Foundation.)

Figure 3. A 44-year-old poliomyelitis case and death rate record from the United States covering the period 1910-1954. From Paul, J. R.: *Clinical Epidemiology*. Univ. Chicago Press, 1958. (Basic data from the Communicable Disease Center, U.S. Public Health Service.)



much. Obesity has become a national disease in the United States. We are becoming more dependent on labor-saving devices than ever. This is a contagious tendency and we are prone to seek a life in which one pushes buttons in order to avoid physical exertion. On all these habits and ways of twentieth century life, the diseases of the second half of the twentieth century will depend, and so entrenched are these habits that it would sound out-of-order to say much against them. And yet, when I think of Doctor Chapin and his courage in facing up to the problems of his day,—one wonders whether we can pay tribute to this man without in some way following his example. It is unlikely that he would be indifferent to the present scene and it is probable that he would be measuring factors which he deemed were responsible for modern diseases.

However, the present scene is not all our fault. This pattern also depends on the effect which one disease has upon another. It sounds complicated, but biostatisticians tell us that no disease can be eliminated or reduced in rate without its having an effect on the rates of all the other diseases to which man is heir. Thus, as the acute infectious diseases, which often attack young people, are brought under control, debilitating and degenerative diseases begin to take over a little later in life. Another effect is that of postponing the time at which a given disease is acquired. An illustration of this trend can be found in a familiar disease,—poliomyelitis. It is now recognized that during the past half century or more the epidemiologic behavior of poliomyelitis has been undergoing an evolution. Under primitive sanitary conditions poliomyelitis did not amount to much. For example, prior to 1900 this disease was uncommon and regarded pretty much as a curiosity. It had a different name,—“infantile paralysis,” for it was a disease then largely restricted to infancy. How different that is from the present generation when “polio” came to be regarded as a dreaded scourge which before the days of the Salk vaccine was ever on the increase in this country and ever more prone to attack older children and even adults. This ominous trend occurred in many countries, notably Scandinavia, Western Europe, North America and Australia. What the story has been in the U.S.A. is illustrated in Figure 3. However, evolutionary experiences of this kind have not been universal, for in many parts of the world, notably in North and South Africa, Egypt and the Middle East, and in certain countries in Latin America, the transition from sporadic “infantile paralysis” to epidemic poliomyelitis has apparently not yet begun. All of these latter countries could be called primitive as regards sanitary arrangements by our standards. In other words, mild, endemic poliomyelitis still persists in those areas with substandard sanitation. Severe, epidemic poliomyelitis has come

to the most advanced countries and has remained there.

In seeking an explanation for this apparent paradox, the opinion has been expressed that the epidemic behavior of “modern polio” is associated with those public health measures or those circumstances which are effective in raising the level of environmental sanitation, within a given area. This would have been a most disturbing opinion in the days of Sedgwick and Biggs. In an attempt to find out more about this, Payne of the World Health Organization has recently drawn attention to the inverse relationship between *infant mortality* rates collected from a wide variety of nations throughout the world, and the *recorded incidence* of poliomyelitis. Infant mortality rates are generally considered as an index of certain types of environmental sanitation, and, in other words, as sanitation improves, infantile mortality rates nearly always go down, and somewhat surprisingly poliomyelitis rates nearly always go up during the same general period of years. This is shown in Figure 4. It does not mean that the decrease in the infant mortality rate

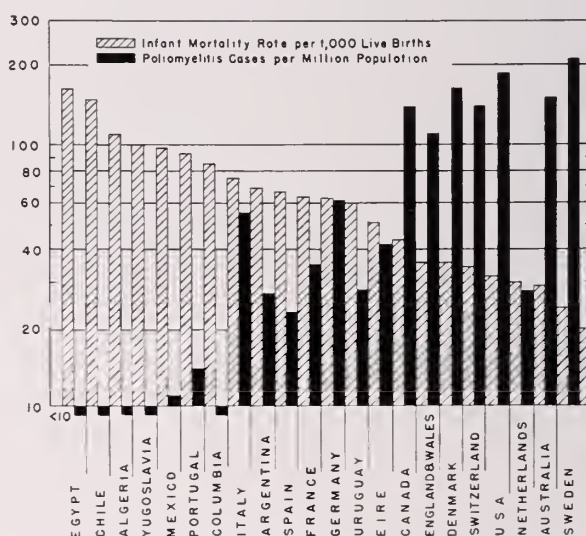


Figure 4. High infant mortality rates have been associated with low poliomyelitis rates in some countries, and vice versa. From Paul, J. R.: Clinical Epidemiology. Univ. Chicago Press, 1958. (Basic data from Payne, A.M.-M.: Papers and Discussions presented at third International Poliomyelitis Conf., 1954. Philadelphia, J. B. Lippincott Co., 1955.)

is directly responsible for an increase in poliomyelitis, but one can easily imagine reasons why these rates can both be affected inversely by the same process. For, the suppression of opportunities for the infant to acquire enteric infantile disease of a variety of different kinds, can at the same time, suppress opportunities for the acquisition of poliovirus infections, which, *if acquired during infancy*, are apt to be very mild affairs. More than 99% of such infantile poliovirus infections are negligible as far as causing symptoms. They are inapparent

infections, from which the infant gains some immunity. This is the most salutary form of natural immunity and as you may know it is the present basis for proposing a live virus vaccine for poliomyelitis to supplant or supplement the Salk vaccine. If, on the other hand, the infant is so protected during the early years of life that he fails to acquire these inapparent infections from local strains of poliovirus, he may subsequently reach school age having failed to gain any immunity to this infection. At this age, *i.e.*, by the time the same child enters school or later, a poliovirus infection is apt to be more severe and by college age still more severe. Less than 99% of infections are subclinical and that segment of the population which is non-immune grows larger each year until an epidemic comes. As such, *postponement* of poliovirus infections by sanitary methods along with a failure to vaccinate, tends to bring poliomyelitis out into the open as it were, and to bring on epidemics with reported attack rates for paralytic poliomyelitis which are higher than were those recorded in the days of "infantile paralysis." It is small wonder that one looks back to the days before the Salk vaccine as to a somewhat sinister situation. It seemed to go directly opposite to the tenet that one could achieve perfect health through cleanliness. One might even suggest that sanitation had backfired as far as this disease was concerned.

One could quote other examples of disease which are characteristic products of our present way of life. The new penicillin resistant staphylococci which have found their way into an apparent vacuum created by the use of antibiotics, is another example, and the sizable number of cases of serum hepatitis which have resulted from the increasing uses of transfusions and parenteral medications is another case in point. I hesitate to mention further examples because each one raises such a long list of new questions which offer a great challenge to modern epidemiology.

Apparently there are all too few people like Doctor Chapin, who began almost fifty years ago to consider this question of variation in disease, and what does it mean. Let us hope there will be others like him,—men who will recognize what is going on around us and who will measure carefully before advising their therapy,—or proposing reforms, so that the facts can speak. These men will not be the kind who plan to cleanse the world of disease. They will seek to find some means of grappling with the problem of illness in a world where living things, be they viruses or men, are both struggling to survive. These men will also recognize that "the road leads up hill all the way,"—but at least it leads up.

## REFERENCES

- <sup>1</sup>Winslow, C.-E. A.: *The Conquest of Epidemic Disease*. Princeton University Press, 1943
- <sup>2</sup>Emersen, H.: Foreword in *Papers of Charles V. Chapin, M.D.*, edited by C. L. Scamman, New York, Oxford University Press, 1934, pp. vii-xii
- <sup>3</sup>Chapin, C. V.: *The Science of Epidemic Diseases*, *Scientific Monthly*, 26:481-493
- <sup>4</sup>Chapin, C. V.: Changes in type of contagious disease. *J. Prev. Med.*, 1:1, 1926-27
- <sup>5</sup>Paul, J. R.: *Clinical Epidemiology*, Chicago, Univ. of Chicago Press, 1958
- <sup>6</sup>Morris, J. N.: *Uses of Epidemiology*, Edinburgh, E. & S. Livingstone, Ltd. 1957
- <sup>7</sup>White, P. D.: The cardiologist enlists the epidemiologist, *Am. J. Pub. Hlth.*, 47:1, 1957
- <sup>8</sup>Dubos, R.: *Mirage of Health*, New York. Harper and Bros., 1959



(Providence Journal Photo)

Doctor John R. Paul (right), Professor of Preventive Medicine at Yale University Medical School, is congratulated by Doctor Francis B. Sargent, President of the Rhode Island Medical Society, for being selected as the eighteenth Charles V. Chapin orator.

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## OUR ALLIES — THE HOSPITALS AND BLUE PLANS: ASSETS OR LIABILITIES? \*

FRANCIS B. SARGENT, M.D.

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*The Author, Francis B. Sargent, M.D., President of the Rhode Island Medical Society, 1958-59.*

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AT THIS MEETING it is customary for the retiring president to give an account of any special and important business transacted by the Society in behalf of the members during his year in office. He also is expected to speak on some subject of vital importance to the Society and concerning which he has made a special study.

After many meetings, and intensive study by a special committee, a Physicians Service contract for subscribers in the medium income group has been formulated. It has been accepted by the House of Delegates of the Society and Physicians Service, and we expect the insurance to be available to the public in the immediate future.

The Committee on Group Professional Liability Insurance has negotiated through Starkweather and Shepley a contract with the St. Paul Fire & Marine, replacing our arrangement with the Lumbermen's Mutual, which became progressively more unsatisfactory with each passing year. The crisis came, when having sustained practically no loss and having collected tens of thousands of dollars in premiums, the company went to the insurance commissioner requesting a substantial increase in rates. This action was done without our knowledge and when rejected, the company served notice of withdrawal from the writing of malpractice as of May 1, 1959. Our professional liability insurance committee deserves our thanks for finding a satisfactory replacement. It would be a shame if we had to downgrade our present high quality of medical care because of the specter of litigation. By providing adequate and certain coverage, your Society hopes to prevent this situation from happening here.

Recently, the president was authorized by the Council to appoint a potentially very important committee to act with our allies, the hospitals and Blue Cross, in two important areas. The first is our mutual defense against outside attack; the second, to resolve conflicts of interest among us as they arise.

This action brings us directly to an evaluation of our allies—the Blue plans and voluntary hospitals—in our struggle for survival.

If any of you entertained any doubt about the wisdom of the Society's opposition to Medicare, it certainly should have been dispelled by the appearance of the Forand Bill. Sponsored by the big labor bosses and federal bureaucrats, this legislation is meant to embarrass our profession and its allies. It cleverly puts us in the position of resisting better medical care for the weak and helpless. The technique, though shopworn, is still used to advantage to harass us. The bill, if passed, will be a great step toward federal operation of Blue Cross and the eventual control of voluntary hospitals. The social planners hope we will choose a lesser evil—the control of hospitals and clinics by labor.

In evaluating the strength and weaknesses of our allies from the doctors' point of view, consider first the Blue Shield, or in this state, Physicians Service. This is our organization. It is under our control through our House of Delegates which elects the governing board by a majority vote from candidates freely nominated from the floor. There is not even the restriction of a nominating committee. Every member of the House is free to express his opinion in a forthright manner.

In a social system where saving for a rainy day is out of fashion, where the public relies on time payment and prepayment plans to take care of expenditures, the injection of a third party into doctor-patient relations becomes a necessity. Of course it increases the over-all cost to the public. So does any insurance plan. To meet this need our Physicians Service is just about ideal. It is 100% an asset and in no way a liability. This is not equally true of the operations of our other major allies in the health field, the hospitals and Blue Cross, both of whom are prime targets for our most vocal critics—the big labor bosses.

Great advances in the quality and availability of medical services have been made possible by the expansion of our hospital facilities. We are indebted to the unselfish efforts of the dedicated members of our hospital boards of trustees and their equally dedicated directors. They have made it easy for us to give our patients a high quality of hospital care. However, the able administrator of a hospital

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\*Presidential Address delivered at the 148th Annual Meeting of the Rhode Island Medical Society, at Providence, Rhode Island, May 13, 1959.



poses certain problems for us. A director is obviously desirous of running a very efficient organization. He will endeavor to make every member of that organization believe that the hospital is the most important thing in that individual's life. No doubt on that matter will ever be allowed to cross the subject's mind. In his zeal to improve care and efficiency in the hospital he may produce groups of doctors who will be a flock of sitting ducks for the power hungry.

From our point of view we want doctors to have more influence, not less, in hospitals. We feel that practicing physicians should support their hospitals, not be supported by them. We can accomplish this by more voluntary contributions on the part of the staff toward the operating deficit of hospitals. Such action will foster in us a sense of responsibility and concern in the operation of the hospitals. It is still true that he who "pays the fiddler calls the tune." Our safety demands that we do not allow hospitals to compete with private practitioners in the care of patients. The men of good will who operate our hospitals may see only immediate public benefit in hospital sponsored clinics, and not the ultimate damage done to our free enterprise system, only under which the best medical care is possible.

Labor will certainly continue to push for its own clinics and hospitals as it launches an attack on the high cost of medical care. Except in special situations such as the care of the aged or indigent, the leaders of labor are no more sold on government medicine than we are. Labor wants more efficient and less expensive medical care. Using state medicine as a bogey man they are gradually setting up clinics and hospitals for the members of their organization and the families of members, under a closed panel system, of course.

This clash between labor and medicine is a tragic one. No one rejoiced more at labor's gains in the thirties than did the doctors, who saw in a better distribution of the profits of industry a realization of simple social justice. The labor bosses are now beginning to realize as well as we do that continuing raids on the profits of industry and the savings of the thrifty will eventually kill the geese that have been laying labor's golden eggs. For this reason, they are looking around for services for the worker at lower cost and here is where we enter the picture. They would put us in the same position as the farmer who pays a very high price for his freedom by working long hours at low returns. The opportunity to put pressure on us comes at a time when, in the words of a great prelate, "the public mind has been psychologically unsettled by the welfare state."

Here are the high points in labor's attacks:

1. Blue Cross, and most Blue Shield plans, require hospitalization for the realization of

benefits. The plans result in longer hospital stays and over-utilization of services.

2. The rise in the cost of hospital care has been the largest price rise of all, rates being up 256% since the war.
3. The race of insurance coverage plans to keep up with what the surgeon charges is futile.
4. Unlimited free choice of physician is a failure. People choose quacks for doctors.

In answer to No. 4, perhaps it would be proper for the labor boss to choose a man's food, his clothing, his housing and even his wife. If the worker selects his own, he might make a mistake.

In essence, criticisms 1, 2 and 3 attempt to combine the technique of one-tenth truth and nine-tenths half-truths. Labor is attempting to set itself up as champion of the people against the high cost of sickness. However, its concern over the high cost of hospital care does not extend to certain other areas: e.g., if a worker buys a \$3,000 car on time payments, he usually ends up paying an extra \$1000 for interest and other charges. This extra charge would take care of the cost of Blue Shield and Blue Cross for eight years even in the highest income plans. These plans cost only two-thirds as much as a family, which uses two packages of cigarettes daily, spends for tobacco. The recent attempt of certain labor leaders to organize the nonprofessional employees of hospitals raises the question—are they interested in lowering hospital costs or are they interested in the control of everybody and everything?

The rising cost of medical care has not been due to higher fees for physicians. Actually, surgical fees have advanced only fifty per cent as fast as the wages of labor; house calls and office visits have advanced only fifty-nine per cent as fast.

There is no doubt in anyone's mind that the cost of hospital care has risen steeply. But seventy-one per cent of the hospital's expense is for wages for employees. Thus labor's gains have been responsible in no small measure for the steep rise in hospital bills.

Although concentration of such services as X-ray and laboratory work in the patient's hospital day has helped shorten his stay there, these same services have contributed to the rise in costs, costs which cannot be reduced except by reducing in some measure the high quality of service.

There may well be some grounds for the criticism that Blue Cross and similar plans encourage over-hospitalization and over-utilization of hospital services. It is only natural that the public, having paid the insurance premium, is anxious to collect on what it considers its investment. One study in the midwest reaches the conclusion that overuse of hospitals accounts for as much as twenty per cent of the total patient days!

*concluded on page 384*

## IATROGENIC DISEASE\*

ANTHONY CAPUTI, M.D. AND JANIS GAILITIS, M.D.

The Authors. *Anthony Caputi, M.D., Cardiologist and Senior Physician, Newport Hospital, Newport, Rhode Island. Janis Gailitis, M.D., Associate Physician, Newport Hospital, Newport, Rhode Island.*

**I**ATROGENIC DISEASE has been a major problem of medical practice since the earliest days of medicine. The past twenty-five years, but particularly the past decade, have been a revolutionary period in the drug therapy of disease! Drugs have been released in large volume since the advent of the age of chemotherapeutics and tranquilization; the benefits have been many but the danger of drug intoxication has increased. The problems of therapy have been affected by the advertising of all types of drugs through many channels including journal advertising, drug literature and salesmen.

In a very comprehensive article Barr<sup>3</sup> discussed the hazards of modern diagnosis and therapy. Drug intoxication, due to digitalis and bishydroxycoumarin (dicumarol), modification of the internal environment by potent diuretic therapy, allergic reactions of various types, and the dangers of mechanical procedures, including accidents, were among the many topics analyzed. There were major toxic reactions in 1,000 cases studied, an iatrogenic incidence of 5%. An article by Lepper<sup>4</sup> reveals the wide scope of the subject and the inadequacy of case record summaries in discovering all cases.

The purpose of this report is to evaluate the incidence of iatrogenic disease in medical hospital admissions.

### Material and Methods

This study extends over a one-year period, from January 1, 1958 to December 31, 1958, and includes 1,604 cases. All medical admissions were evaluated by data analysis of charts. It is clear that certain facets of iatrogenic disease escaped discovery in spite of excellent chart material. For instance, some febrile episodes were not explained in the progress notes. The nurses' notes proved valuable in the accurate determination of iatrogenic problems. Psychiatric iatrogenic problems could not be evaluated, and this fertile and important field was eliminated

\*Presented at the 148th Annual Meeting of the Rhode Island Medical Society, at Providence, Rhode Island, May 13, 1959.

by the nature of the study. Errors of commission and omission involving diagnosis and treatment would not yield to accurate evaluation.

The analysis of 1,604 cases resulted in a breakdown of data into five categories (Table I): I) Drug Intoxication; II) Mechanical Factors and Procedures; III) Hospital Infections; IV) Transfusion Reactions; V) Modification of Internal Environment. Each of these categories is illustrated by a case presentation when indicated.

### I. Drug Intoxication

Extension of pharmacologic effect is the major problem in medical practice. As anticipated, digitalis, dicumarol and other anticoagulants, and insulin played the major roles. Dicumarol particularly exemplifies the extremes of pharmacologic effect, i.e., a tendency to bleeding and prothrombin escape. Other problems included vitamin deficiency syndromes, cortisone induced gastrointestinal bleeding, bone marrow depression, superinfection secondary to cortisone therapy, gastric retention and syncope. Anaphylaxis and allergy applied particularly to penicillin and included four cases in 1,604 admissions, an incidence of 0.25%. Welch, et al<sup>4</sup> conducted a nationwide survey on severe reactions to antibiotics. Of 1,070 severe reactions, 809 were of the anaphylactoid type, and 793 resulted from penicillin. One of our cases was of the severe anaphylactoid type with recovery. The cases in this group totaled 64. Following are case summaries illustrative of this group:

M.W.—a fifty-seven-year-old colored female developed shock, wheezing respirations and laryngeal stridor immediately following an injection of 600,000 units of procaine penicillin for

TABLE I  
1,604 Medical Cases  
January 1, 1958 through December 31, 1958  
Incidence of Iatrogenic Disease

Category	Cases
Drug Intoxication	64
Mechanical Factors and Procedures	30
Hospital Infections	7
Transfusion Reactions	10
Modification of Internal Environment	3
Total Cases	114
Incidence	7.1%



treatment of a mild acute upper respiratory infection. She recovered from this near-fatal penicillin induced anaphylactic reaction following heroic therapy with epinephrine, vasopressor agents, oxygen, corticosteroids, penicillinase and antihistamines. Subsequent electrocardiograms revealed an anterior wall myocardial injury pattern that required prolonged hospitalization for eventual recovery.

B.M.—an eighty-six-year-old white male was treated in the hospital with soluble heparin averaging 200 mg. daily, in divided doses, for the treatment of an acute myocardial infarction. At the time of a massive gastrointestinal hemorrhage which proved fatal, the Lee-White coagulation time was 40 minutes. Therapy included fresh blood transfusions and protamine.

## II. Mechanical Factors and Procedures

This category includes injuries, falls, pressure dermatitis and decubitus ulcers, fecal impactions, and a case of pulmonary fibrosis postradiation therapy. A very important mechanical problem is that of catheterization—mechanical cystitis is an invariable accompaniment of the indwelling catheter with ascending cystopyelitis as the sequel. There are thirty cases in this group and the following case is illustrative.

D.G.—a forty-one-year-old white female, without genito-urinary symptoms, was catheterized because of a complaint of low back pain. Urinalysis was negative. Shortly thereafter she was hospitalized with acute pyelonephritis as revealed by a urine culture containing over 100,000 colonies of *E. Coli* per 1 ml. After sensitivity studies, therapy was commenced with the appropriate drug and eventual recovery after two weeks of hospitalization.

## III. Hospital Infections

Recognized hospital infections included seven cases. Catheterization of the urinary bladder seemed to be the major cause in this group. Secondary pneumonias including micrococcus pyogenes as the etiologic group included the remaining cases. The problem of hospital infections is well reviewed by Taylor<sup>7</sup> and measures for control are outlined. The following case illustrates one aspect of the problem.

L.S.—an eighty-six-year-old white female was hospitalized for the management of left ventricular failure secondary to arteriosclerotic heart disease. A bronchopneumonia due to coagulase positive micrococcus pyogenes developed. This strain was resistant to all tested chemotherapeutic agents and the patient subsequently expired from the hospital acquired infection.

## IV. Transfusion Reactions

There are many types of transfusion reactions, but the ten cases observed in this survey were generally of the delayed pyrogenic type. Harrison<sup>6</sup> indicates the incidence of pyrogenic reactions at 2.9%, and that of other reactions at 5%. It is believed that small thrombi, rubber tubing contaminants and small numbers of bacteria may produce pyrogenic reactions. No reaction was serious. Therefore, an illustrative case is not presented.

## V. Modification of the Internal Environment

Homeostasis<sup>7</sup> is based on the interplay of many factors which to list a few include: fluid transport through vessels; kidney and hormonal regulation; fluid movements and concentration changes. Of course, the external environment is intimately related to host defense and the preservation of the organism. Alteration of homeostasis included only three cases in this series. Following is an illustrative case.

C.T.—a fifty-five-year-old white male with obstructive emphysema, bronchopneumonia and severe respiratory failure developed mental confusion, lethargy and irregular shallow respirations due to carbon dioxide narcosis while in an oxygen tent. Removal from this environment reversed the process in two hours with eventual recovery.

## CONCLUSIONS AND SUMMARY

The physician has received much unwarranted criticism from the lay and professional press concerning iatrogenic disease. The term "iatrotechnical" is actually more descriptive and accurate. When disorders have been instigated by suggestion, examination or discussion by the physician they are termed iatrogenic. Conditions that are induced by technical procedures employed by physicians in medications, operations, procedures or examinations are termed iatrotechnical. Wakefield<sup>8</sup> has summarized these problems in excellent perspective. It is interesting to note the high incidence of iatrotechnical disease in this study of 1,604 cases—114 cases—or 7.1% of the total. While there were numerous problems involved, actual prevention of iatrotechnical disorders would have been difficult. The inherent risks in therapy are well recognized. Anticoagulant, digitalis, insulin and blood transfusion reactions are frequently observed. Catheterization of the urinary bladder should be restricted to absolute indications. The prevention of injury from falling out of bed has been reduced by the newer type of Hi-Lo bed. May<sup>9</sup> has pointed out that physicians are not the only ones involved in iatric problems. Parents are also responsible for difficulties such as toxicity of vitamin therapy in children.

*concluded on next page*



Prevention of iatrogenic disease will not be possible in all instances, but constant adherence to the following rules will minimize the problem:

1. Avoidance of routine orders;
2. Awareness of strict drug indications, pharmacology of the compound and possible side effects;
3. Delay in the use of new drugs until clinical trials have been extensive;
4. Restriction of the duration of therapy, with flexibility of regimen adjusted to the changing status of patient;
5. Appreciation of the natural history of disease, including remissions;
6. Avoidance of multiple drug therapy which in some cases totaled six to eight agents;
7. Appreciation of other modalities of therapy.

#### BIBLIOGRAPHY

- <sup>1</sup>Wilkins, R. W.: The First Decade, 1957 Annual Report, American Heart Association
- <sup>2</sup>Farrar, G. E., Jr., Nolle Nocere: American College of Physicians Meeting, Atlantic City, (April 30) 1958
- <sup>3</sup>Barr, D. P.: Hazards of Modern Diagnosis and Therapy—The Price We Pay. Frank Billings Memorial Lecture, J.A.M.A., December 10, 1955
- <sup>4</sup>Welch, H., et al.: Severe Reactions to Antibiotics: Nationwide Survey: Antibiotics and Chemotherapy 4:800-813, December 1957
- <sup>5</sup>Caswell, H. T., et al.: Bacteriologic and Clinical Experiences and Methods of Control of Hospital Infections Due to Antibiotic Resistant Staphylococci. Surgery, Gynecology & Obstetrics 106:1-10, January 1958
- <sup>6</sup>Harrison, T. R.: Principles of Internal Medicine, Vol. II, 3rd ed., Section 2-270, McGraw-Hill
- <sup>7</sup>Statland, H.: Fluids and Electrolytes in Practice, Chapter II, 2nd ed., Lippincott
- <sup>8</sup>Wakefield, E. A.: Clinical Diagnosis, pp. 30-31, Appleton-Century-Crofts, Inc.
- <sup>9</sup>Editorial Views, Scope-Weekly, Comments from the Journals, Iatrogenic Disease. The Upjohn Company, Kalamazoo, Mich.

#### OUR ALLIES—THE HOSPITALS AND BLUE PLANS: ASSETS OR LIABILITIES?

*concluded from page 381*

It is readily apparent that a closer understanding between physicians, the hospitals and the Blue Cross is imperative if the problem is to be solved. If Blue Cross is unable to cope with the constantly rising cost of hospitalization, it faces the danger of being taken over by the federal government. If that threat becomes imminent, then a divorce of Blue Shield and Blue Cross becomes not only advisable, but imperative.

On balance, the value to us of the voluntary hospital and Blue Cross is great, the liability factor is negligible, if we remain consistently aware that each presents a calculated risk.

*Keep Well and Out of the Hospital* is the caption of one issue of labor's health and welfare magazine. This is the most constructive advice they have contributed. Certainly anything we as doctors can do

to shorten a patient's hospitalization will relieve the present intolerable load on distracted nurses and hospital administrators. Within the limits of safety, we should do everything in our power to discourage unnecessary hospitalization, and also to effect short stays. If each of us can save Blue Cross three hospital days a week, and if this is done on a country-wide basis, the plan, and ultimately its subscribers, would save about 500 million dollars yearly.

As a profession we vigorously support the principle of private enterprise. Prudence demands that we oppose the welfare state in general and the regimentation of medicine by outside controls in particular. In general, because the welfare state and its eventual collapse will be nature's lethal remedy for overpopulation, and in particular, because it will rob us of a unique opportunity to serve the public. With the tremendous advances in medicine in the past four decades our ability to cope with human misery is without precedent. The public, now poorly informed and comparatively helpless in matters medical, deserves from us a generous return for its contributions to research.

Any differences with the American Hospital Association and the Blue Cross must be resolved. We will all hang together or separately. Our cause must be presented competently to the public by every means of communication. It must be made clear that only when an individual directly or indirectly pays his own way can he have free choice of physician and hospital.

The federal government has now become of paramount importance in any consideration of the future. If we are to have any place in the future we must follow the tactics of labor leaders and take an interest in political problems and candidates for office. As individuals we must enter politics to the extent of investing considerable time and money. We can never be a force in government without having a part in the selection of those who run it.

As a result of the activities of those who have mastered the technique of brain washing through mass propaganda and who destroy the integrity of the individual by taxing quietly and spending loudly, we find a preponderance of brutal force arrayed against us in our fight against regimentation. The intangibles, however, are on our side. Not the least of these is the fact that we have in our minds and hands the capacity to render dedicated service that money cannot pay for, that dictators and bureaucrats cannot give.

#### Interim Scientific Meeting

**WEDNESDAY . . . SEPTEMBER 23**

## THE RHEUMATIC FEVER PROGRAM

### As Administered Through the Division of Maternal and Child Health of the Rhode Island State Department of Health

**T**HE Rhode Island State Department of Health, through the Division of Maternal and Child Health, administers the Rheumatic Fever Program.

At each rheumatic fever clinic, two types of service are offered:

1. *Diagnosis and treatment:* Children who are referred directly to the program by physicians and hospital clinics will be accepted for complete care, that is, any necessary medical, hospital or convalescent care during the time the child is under the care of the program. This service is available to families who are unable to provide private medical care.

2. *Consultation service:* Consultation service is offered to physicians for their private patients. This includes complete laboratory investigation, EKG, X ray and complete physical examination by a qualified cardiologist and pediatricians who are experienced in the investigation of rheumatic fever and rheumatic heart disease. The complete reports are sent to the referring physician.

3. *Congenital heart disease:* A limited amount of money is available for children who have congenital heart disease which is amenable to surgery. Recent advances in diagnostic studies and surgery have made this program a very important one. Even though the incidence of these anomalies is low, the cost often is beyond the means of the average family. The State Rheumatic Fever Program is offering its services to a limited number of children who have congenital heart disease which is amenable to surgery.

The evaluation will include diagnostic laboratory test, EKG, X ray and cardiac catheterization and cardioangio-cardiography to be done at one of the three hospitals in Rhode Island where this procedure is in operation.

Children who can be benefited by corrective surgery within approximately a year's period will be accepted on the program.

Children with congenital heart disease who, at the present time, cannot be benefited by corrective surgery will not be accepted for treatment under the Rheumatic Fever program. These children will be referred back after the above evaluation to the referral source with complete copy of the findings.

If, in the future, corrective surgery has been established for the congenital defect, the children may be referred back to the Rheumatic Fever pro-

gram.

*Who is eligible?* All children under twenty-one years of age who are residents of Rhode Island and who have rheumatic fever, rheumatic heart disease or any condition leading to rheumatic fever or rheumatic heart disease or who have congenital heart disease which can be benefited by surgery may be referred by their private physician or hospital clinic physician.

*Clinics are held at:* Rhode Island Hospital, Charles V. Chapin Hospital, Memorial Hospital, weekly; St. Joseph's Hospital, biweekly; Woonsocket Hospital, Warwick District Nursing Association, West Warwick District Nursing Association, monthly.

*What the clinics offer:* Complete physical examination by a qualified physician; complete laboratory facilities; X-ray and fluoroscopic examination, if indicated; nutrition services; medical-social services; follow-up services; convalescent care, if needed; doctor's visits to home for those under the program; hospitalization, if indicated, and medication.

*What does it cost?* Service is available free of charge to all patients accepted on the program. Consultation and diagnostic services are also free.

*How can you refer your patients?* Call Jackson 1-7100, Extension 233, or write to the State Rheumatic Fever Program, Room 323, State Office Bldg., Providence. Appointments for clinic are made from the central office.

*The rheumatic fever and congenital heart programs are financed 100% by state funds.*

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## OFFICERS INSTALLED FOR 1959-1960

### THE RHODE ISLAND MEDICAL SOCIETY

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**D**OCTOR ALFRED L. POTTER, Providence obstetrician and gynecologist, was installed May 13 as the 100th president of the Rhode Island Medical Society, the nation's ninth oldest state medical association. He was unanimously elected by the Society's House of Delegates to succeed Doctor Francis B. Sargent.

Other officers elected and installed were Doctor Earl J. Mara, Pawtucket internist, as president-elect; Doctor Samuel Adelson of Newport, re-elected vice-president; Doctor Arthur E. Hardy of Warwick, secretary, and Doctor J. Murray Beardsley, treasurer.

The new leader of the state medical society is a native of Orange, Massachusetts. He received his high school training at Providence Classical, and he was graduated from Cornell University with a degree of bachelor of arts. In 1918 he received his doctor degree of medicine from Cornell Medical School. He served internships at Woman's Hospital and New York Lying-In Hospital prior to coming to Providence to establish his private practice. He also served for two years as a medical officer at the United States Naval Hospital in Brooklyn.

Chief of Staff at Providence Lying-In Hospital from 1946 to 1954, Doctor Potter has since been a member of the consulting staff. In addition, he is a member of the gynecological staff at Rhode Island Hospital and a consulting surgeon at both Pawtucket Memorial and Charles V. Chapin hospitals. He is a former clinical professor of obstetrics at Tufts Medical School, and a former lecturer in obstetrics at Harvard Medical School, and he was at one time an instructor in anatomy at Cornell Medical School.

#### *Active in Medical Society Affairs*

Doctor Potter has played a major role in medical society activities serving as assistant secretary of the state medical society from 1942 to 1946, as president of the Providence Medical Association in 1953, as president of the New England Obstetrical and Gynecological Society, and also as president of the nation's oldest obstetrical association, the Obstetrical Society of Boston. He has been a member of the House of Delegates of the Rhode Island

Medical Society for many years, and he recently headed the committee which reported on insurance problems for health care of older-aged persons.

#### *Doctor Adelson Re-elected Vice-President*

Doctor Samuel Adelson, Newport surgeon, who has had a long and active career as a member of the Council of the Society, as well as a member of the House of Delegates, was re-elected to a second term as vice-president.

A past president of the Newport County Medical Society, Doctor Adelson has also combined an outstanding civic career with his medical practice. He has been chairman of the representative Council of the City of Newport, secretary of the Board of Health, a member of the City Charter Commission, medical examiner in Newport County, and more recently, chairman of the Newport High School Commission.

#### *Pawtucket Leader Named President-Elect*

A lifelong resident of Pawtucket, Doctor Earl J. Mara will succeed Doctor Potter as head of the medical society in 1960. He completed his elementary and high school education at Pawtucket, and he was graduated from Georgetown University with a degree of bachelor of science in 1931. Two years later he received his medical degree from the Georgetown Medical School.

Doctor Mara returned to Pawtucket for an internship at Memorial Hospital, where he is now chief of the Department of General Practice and director of the Outpatient Department. He is also a member of the staff of Notre Dame Hospital in Central Falls. A past president of the Caduceus Club, the Pawtucket Medical Association, the Memorial Hospital Staff Association, and the Memorial Hospital Interns' Association, Doctor Mara has long been active in the state medical society activities as a member of the House of Delegates, the Council and as chairman of the committee on social welfare.

#### *New Treasurer Named by Delegates*

Doctor J. Murray Beardsley, surgeon-in-chief at Rhode Island Hospital, was named by the House of Delegates to succeed the late Doctor Francis V. Garside as treasurer of the Society. Doctor Beards-



ley was treasurer of the Providence Medical Association from 1947 to 1950.

A native of Nova Scotia, he completed his elementary and collegiate studies there, receiving his degree in medicine from Dalhousie University in Halifax. After an internship at Rhode Island Hospital, and a residency at the New York Skin and Cancer Hospital, Doctor Beardsley established his private practice in Providence. He holds staff positions with most of the hospitals of the state, and he was named surgeon-in-chief at Chapin Hospital in 1946.

He has been a member of the Board of Governors of the American College of Surgeons, a member of the executive committee of the New England Surgical Society and the New England Cancer Society, a member of the Board of Directors of the Rhode Island Cancer Society, and president of the Providence Surgical Society, in addition to many other honors. Governor Del Sesto recently named him to a three-year term on the Medical Advisory Committee of the State Workmen's Compensation Commission.

#### *Standing Committee Chairmen*

Eight major committees, designated as Standing Committees whose personnel is selected by the House of Delegates, were elected and officially inducted. The following physicians were named as chairmen of these committees: Medical Economics, Doctor Stanley D. Simon of Providence; Scientific Work and Annual Meeting, Doctor Alex M. Burgess, Sr. of Providence; Public Laws, Doctor James H. Fagan of Providence; Publications, Doctor John E. Donley of Providence; Medical Defense and Grievance, Doctor Francis B. Sargent of Providence; Industrial Health, Doctor Stanley Sprague of Pawtucket; Library, Doctor Francesco Ronchese of Providence; and Public Policy and Relations, Doctor Arnold Porter of Providence.

#### ANNUAL MEETING OF STATE PATHOLOGISTS

The sixth annual joint meeting of the Rhode Island Society of Pathologists, Inc., with the Laboratory Club of Rhode Island, was held on May 19, 1959, at the Pawtucket Memorial Hospital. Eighty-five were in attendance, including eight members of the Society of Pathologists.

A scientific program was presented with Doctors Herbert Fanger and Joseph Song of Rhode Island Hospital reporting on the *Rhode Island Women's Cancer Cytology Survey in Cancer Detection*, Doctor David Greer of Truesdale Hospital, and Mrs. Theresa B. Escobar, discussing *Blood Ammonia Determinations:—Methodology, Interpretation of Results*; Doctor Fanger and Miss Barbara E. Barker, president of the Laboratory Club of Rhode Island, reporting on *Histochemistry of Breast Diseases*; and Mr. Thomas Connor, technologist of St. Joseph's Hospital, discussing *Clinical Application of Electrophoresis*.

#### RECORD LIBRARIANS ELECT

The Annual Meeting of the Rhode Island Association of Medical Record Librarians was held on Wednesday, May 13, 1959, at the Newport Hospital, Newport, Rhode Island. Miss Lois Jomini, C.R.L., presided. Mrs. Anna MacBeth, R.R.L., acted as hostess.

Robert Bestoso, M.D., president of the Staff Association of Newport Hospital, Newport, Rhode Island, was the guest speaker. His subject was *Medical Hypnosis*. He gave a brief history of hypnosis, tracing it back to the very beginning of time. Doctor Bestoso stated that hypnosis had a very definite place in medicine, especially in psychiatry, but stated that it could be rather dangerous if used without proper indications. He outlined the advantages and disadvantages of this type of treatment. He cited several cases in which this method had been very successful. A general discussion followed Doctor Bestoso's lecture.

The following officers for the year 1959-1960 were elected: *President*: Mrs. Mary N. Chase, C.R.L., Veterans Administration Hospital; *Vice-President*: Miss Mary S. Cheever, R.R.L., Kent County Memorial Hospital; *Secretary*: Miss Elizabeth Bingham, C.R.L., St. Joseph's Hospital; *Treasurer*: Miss Virginia Torres, R.R.L., Rhode Island Hospital; *Directors*: Miss Lois Jomini, C.R.L., Rhode Island Hospital, and Miss Gertrude Cahir, R.R.L., Lying-In Hospital; *Delegate to Annual Meeting*: Miss Elizabeth Bingham, C.R.L.

#### RIGHTS UNDER LIMITED MEDICAL LICENSE

I wish to invite your attention to the ruling of this Department concerning certain rights that are conferred upon the holders of limited medical registration certificates that have been issued under the provisions of section 5-37-16.

The holder of a limited registration to practice medicine in a hospital may sign death certificates as the need may arise in connection with his duties. This ruling is based upon an interpretation of the law by the Department of the Attorney General. The opinion stated that the act of signing a death certificate is ministerial rather than discretionary.

We have also ruled that the holders of limited medical registrations may sign papers for commitments for mental diseases.

It is understood, of course, that the right to sign such certificates is confined to the scope of practice provided by the limited registration, i.e., that it applies only to the practice of medicine in the particular hospital and during the specified time covered by the limited registration certificate.

Very truly yours,  
JEREMIAH A. DAILEY, M.D.  
Director of Health

#### PATRONIZE JOURNAL ADVERTISERS

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# The RHODE ISLAND MEDICAL JOURNAL

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## THE "ONE WORLD" OF TRANSMISSIBLE DISEASE

MODERN TRANSPORTATION that brings all parts of the world close together, shrinking the barriers of space and time and making us all neighbors, exposes us all to contagious diseases from the far corners of the earth as never before, despite all our efforts to prevent this. The tick that fastens on the dog in Montana may, after a rapid ride by plane, drop off in Indiana, and the rickettsia which he carries may cause the surprising occurrence of "spotted fever." The man infected with the lurking salmonella in Europe may reach his home in Massachusetts days before the incubation period of his disease has been completed. Many of the barriers which have been erected to prevent the entry of disease-bearing persons to this and other countries are inadequate to meet the challenge of modern speed.

A recent entry in the Congressional Record by Hon. Francis E. Dorn, of New York, calls attention to the marked inadequacy of federal inspection of vessels in the coastwise and foreign trade. Under the law all these vessels must be inspected, a job that requires three man-days in the case of a passenger vessel and one man-day in case of a freighter. What can a force of twenty inspectors and eighteen engineering employees of the Public Health Service do to carry out such a vast program? Such, however, is the size of the staff assigned to this work, according to the article by Mr. Dorn.

If, however, this staff were increased tenfold, or

a hundredfold, we still would face the fact that modern rapid transit between countries means, of necessity, the admission of more infected individuals to our country, and from our country into other lands than ever before. It takes time to develop symptoms after the invasion of the tissues by an infectious agent—and the more rapid the transportation, the more individuals who have become infected will escape detection.

For this reason a knowledge of contagious disease as it exists in all parts of this country and of the whole world will continue to be more and more necessary to the practicing physician. While certain infections will be limited in great part to certain areas because of environmental conditions, even in such instances sporadic cases may occur anywhere—and in some of these correct diagnosis leading to proper treatment may be lifesaving. A history of travel will, of course, usually be of the greatest help, but carriers and people with sub-clinical infections can be the means of causing diseases from far away to appear in people who have never been more than a few miles away from their homes. We shall have to accept the intimate contact with all humanity that is increasingly evident, and must become familiar with all types of transmissible disease. Methods of prevention and treatment must eventually be understood and carried out everywhere as we become more and intimately associated with all the other inhabitants of our "one world."

## THE LUCKLESS LEGION

ON AMERICAN ROADS the carnage by automobiles continues to grow apace and we accept it with what appears to be somnolent complacency, if not indifference. Too few of us seem to be concerned when the press informs us that 310 persons died in traffic accidents during the recent two-day Memorial weekend. This exceeds the old record of 241 for a two-day Memorial holiday set in 1953. The 310 deaths exceeded also the National Safety Council's pre-holiday estimate of 260 for the same period.

This is only part of the tragic story; for the National Safety Council reports that the toll for the first four months of this year was 10,680 deaths—a gain of 4% over the 10,270 deaths in the corresponding 1958 period. In 1958 more than 2,800,000 Americans were involved in automobile casualties.

In its annual highway safety booklet titled *The Luckless Legion*, the Travelers Insurance Company points out that this is an army which grows more rapidly each year. It includes the dead and the injured, the heedless and the innocent, the young and the old. Since the automobile first appeared upon the American scene the ranks of this legion of the dead and the crippled have included

more than 60,000,000 people.

During the past year there were 36,700 men, women and children among the dead of the Luckless Legion. For every fatality there were 77 people who suffered painful injuries which, during the past year, rose 12%, twice the rate of injury for the previous year. During 1959 the Luckless Legion will be enrolling recruits on the highways, in the hospital rooms, in the morgues.

Can nothing be done to diminish this wanton carnage? Well, each of us, if he will, can help a little. When you are tempted to indulge in insensate speed, do not step on the gas; when you have the right of way, do not insist upon taking it, for many dead men had the right of way; do not try to beat the darkness home; respect the red and green lights; when vision, reflexes and alertness are dulled by fatigue or libations, remember the ancient Roman counsel to make haste slowly; beware of speeding when weather and road conditions are bad; avoid jaywalking on crowded streets as you would the pest; lastly, it is well even for physicians to remember always that the innocent internal combustion engine may be used to enhance, maim or swiftly terminate one's earthly career.

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## HOUSE OF DELEGATES of the RHODE ISLAND MEDICAL SOCIETY

### Report of Meeting Held April 15, 1959

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, April 15, 1959. The meeting was called to order by the president, Doctor Francis B. Sargent, at 8:00 P.M. The following delegates were in attendance:

*BRISTOL COUNTY*: Robert W. Drew, M.D.  
*KENT COUNTY*: Edmund T. Hackman, M.D.; Donald K. O'Hanian, M.D.  
*NEWPORT COUNTY*: Philomen P. Ciarla, M.D.  
*PAWTUCKET DISTRICT*: Earl F. Kelly, M.D.; Robert C. Hayes, M.D.; Ferdinand S. Forgiel, M.D.; Alexander Jaworski, M.D.; Harry Hecker, M.D.  
*WASHINGTON COUNTY*: James McGrath, M.D.; Samuel Farago, M.D.  
*WOONSOCKET DISTRICT*: Joseph A. Bliss, M.D.; Saul A. Wittes, M.D.  
*OFFICERS OF THE RIMS* (other than delegates): Francis B. Sargent, M.D. (President); Samuel Adelson, M.D. (Vice-Pres.); Alfred L. Potter, M.D. (Pres. Elect); Thomas Perry, Jr., M.D. (Secretary).  
*PROVIDENCE MEDICAL ASSOCIATION*: J. Robert Bowen, M.D.; Wilfred I. Carney, M.D.; Francis H. Chafee, M.D.; William J. H. Fischer, M.D.; Henry B. Fletcher, M.D.; Frank Fratantuono, M.D.; John F. W. Gilman, M.D.; Seebert J. Goldowsky, M.D.; Stanley Grzebien, M.D.; John C. Ham, M.D.; Walter S. Jones, M.D.; Frank C. MacCardell, M.D.; Arnold Porter, M.D.; Ralph D. Richardson, M.D.; Carl S. Sawyer, M.D.; William J. Schwab, M.D.; Stanley D. Simon, M.D.  
*ALTERNATE DELEGATE TO A.M.A.*: Arthur E. Hardy, M.D.  
*STATE HEALTH DEPARTMENT DIRECTOR*: Jeremiah A. Dailey, M.D.

Also present were John E. Farrell, Sc.D., executive secretary of the Society; Hannibal Hamlin, M.D., chairman, Chapin Hospital Study Committee, and Stanley Sprague, M.D., chairman, Industrial Health Committee.

The president introduced to the House of Delegates Doctor Jeremiah A. Dailey, the new State Director of Health, who by virtue of his office becomes a nonvoting member of the House of Delegates.

#### REPORT OF THE SECRETARY

Doctor Thomas Perry, Jr. read his report, copy

of which was included in the handbook of the delegates and is made part of the official minutes of the meeting.

**ACTION**: It was moved that the report of the secretary be approved and placed on file. The motion was seconded and passed.

#### ELECTION OF OFFICERS

Doctor Earl F. Kelly, chairman of the Committee on Nominations of the Council, noted that the slate of nominees drafted by the Council had been distributed to the delegates in their handbook. He reported that in view of the death of Doctor Francis V. Garside, who had been nominated for treasurer, the Committee wished to place in nomination for the office of treasurer, Doctor J. Murray Beardsley, of Providence.

**ACTION**: The slate of officers as amended, as submitted by the Council of the Society, was approved and the nominees declared elected to serve the Society for the fiscal year 1959-1960.

#### RESOLUTION RELATIVE TO DOCTOR FRANCIS V. GARSIDE

The secretary presented the following resolution:

*WHEREAS*, Doctor Francis V. Garside, a member of the Rhode Island Medical Society from his first year of private practice, brought high honor and commendation to the Medical Profession of this State by his outstanding devotion and service to his patients, and

*WHEREAS*, he also served the Rhode Island Medical Society with distinction as its Treasurer during the past year, and as a member of the Council.

*THEREFORE*, Be It Resolved, That this House of Delegates of the Rhode Island Medical Society, assembled in meeting this fifteenth day of April, 1959, record its regret at the untimely death of Doctor Francis V. Garside, and that it express its sympathy to his family in their, and our, great loss.

The resolution was unanimously adopted by the House of Delegates.

*continued on page 392*

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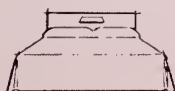


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## HOUSE OF DELEGATES

*continued from page 390***DATES FOR THE 1960 ANNUAL MEETING**

The secretary noted that the dates for the 1960 annual meeting had not been considered by the Council but it was important at this time that the dates be set and therefore he suggested that the house consider the dates of Tuesday, May 10 and Wednesday, May 11, 1960, for the 149th annual meeting of the Society.

**ACTION:** It was moved that the dates as proposed for the 1960 meeting be approved. The motion was seconded and passed.

**TRUSTEE OF THE BENEVOLENCE FUND**

The secretary noted that the term of Doctor Henry J. Hanley as trustee of the Benevolence Fund expires with the 1959 annual meeting of the Society.

**ACTION:** It was moved that Doctor Henry J. Hanley of Pawtucket be renominated for a three-year term as a trustee of the Benevolence Fund. The motion was seconded and adopted.

**COMMUNICATION FROM THE STATE DIRECTOR OF LABOR**

The secretary read a communication from the state director of labor in which he stated it was his intention to renominate Doctor John E. Donley as medical director of the State Curative Center for a five-year term provided such action meets with the approval of the Society.

**ACTION:** It was moved that the reappointment of Doctor John E. Donley as medical director of the State Curative Center be approved. The motion was seconded and unanimously adopted.

**FREE CHOICE OF PHYSICIAN and CLOSED PANEL SYSTEMS**

The president noted that an abstract from the report of the Commission on Medical Care Plans of the American Medical Association had been included in the delegates' handbook. Attention was directed to the request that the delegates express a decision on the following basic points:

**1. Free Choice of Physician**

Acknowledging the importance of free choice of physician, is this concept to be considered a fundamental principle, incontrovertible, unalterable, and essential to good medical care without qualification?

**2. Closed Panel Systems**

What is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician?

There was general discussion of the report and the questions posed by the American Medical Association,

at the conclusion of which the following statement was adopted by the House of Delegates:

The House of Delegates of the Rhode Island Medical Society has reviewed the report of the Commission on Medical Care Plans of the American Medical Association, as reported in the special edition of the JOURNAL OF THE A.M.A., January 17, 1959. The House has given particular attention to Section III, Free Choice of Physician, and Section IV, Third Party Relationships in Miscellaneous and Unclassified Plans.

The Rhode Island Medical Society has cooperated with public and private health and welfare agencies successfully in maintaining high standards of physician care for all citizens, and the principle of free choice by the individual has been maintained with a minimum of restriction. For example, the injured employee has free choice of his physician and his hospital under the Workmen's Compensation law; the welfare recipient has free choice of his physician under a public assistance "pooled fund" or vendor program; the Physicians Service subscriber has free choice of physician whether or not the physician is a "participating physician" under agreement with the Plan; the beneficiary of the state Temporary Disability Compensation program has free choice of his physician.

The House of Delegates of the Rhode Island Medical Society is of the opinion that unlimited free choice of physician is the right of any individual responsible for his own or his dependents' medical care. When a third party assumes responsibility in whole or in part for providing the individual's medical care, a modified or restricted free choice that is necessary by reason of social or economic conditions, can be acceptable and should not be a deterrent to good medical care.

The House does not under any conditions approve of physician participation in any type of closed panel system that denies to the patient a normal physician-patient relationship.

**RESOLUTION RELATIVE TO SOCIAL SECURITY FOR PHYSICIANS**

The secretary noted that a resolution from the Kent County Medical Society had been included in the handbook to the House of Delegates. The resolution was as follows:

That the Kent delegates request that the members of the Rhode Island Medical Society be polled on the following question—

SHOULD THE UNITED STATES CONGRESS PASS LEGISLATION TO INCLUDE DOCTORS OF MEDICINE IN

*continued on page 394*





## *And No Dollar A Year, Either!*

Behind Physicians Service is a board of directors made up of laymen and doctors. All of them are outstanding men in our State. They plan the surgical benefits to be administered to over half a million Rhode Island members.

Physicians Service is run like a business, because that's what it is. Created by legislative authority, the board of directors sits — as does any similar group in industry — to direct policies and keep things running smoothly.

There is a difference, however: these directors serve without pay. They give voluntarily of their time and fulfill their duties as conscientiously as if they were earning high salaries.

These men serve willingly without pay because Physicians Service is a community project. It is a non-profit organization. It was created to help prepay the costs of surgical, medical, or obstetrical care. It provides for medical visits in the hospital and covers surgery in your home, doctor's office or the hospital.

How well this board operates in the public interest is shown by these two facts: 1.) The Rhode Island Physicians Service Plan has the greatest percentage of persons covered of any state in the union; 2.) It operates more economically than any other plan.

From this firm basis have come extensive benefits. In addition, the directors of Physicians Service pledge to continue to offer new benefits whenever studies prove they are needed and are economically feasible.

*Better Health Care for More People Through*

# *Physicians Service*



## HOUSE OF DELEGATES

*continued from page 392*

## SOCIAL SECURITY COVERAGE?

and that

The delegates to the American Medical Association from the Rhode Island Medical Society be instructed to raise the question of Social Security coverage at the next A.M.A. meeting and to vote there according to the wishes of the majority in the Rhode Island state poll.

There was general discussion of the subject.

ACTION: It was moved that the members of the Rhode Island Medical Society be polled on the following question:

## SHOULD THE UNITED STATES CONGRESS PASS LEGISLATION TO INCLUDE DOCTORS OF MEDICINE IN SOCIAL SECURITY COVERAGE?

The motion was seconded and adopted.

\* \* \*

ACTION: It was moved that the poll of the membership on Social Security include the notation that the Rhode Island Delegate to the American Medical Association be instructed by the House of Delegates to vote according to the majority decision of those who answer the Society's poll. The motion was seconded and adopted.

## REPORTS OF COMMITTEES

The reports of the following Committees as submitted in the handbook to the House of Delegates, and as made part of the official records of the meeting, were accepted and approved on individual motions: Benevolence Fund, Blood Bank Committee, Cancer Committee, Child-School Health Committee, Diabetes Committee, Group Liability Insurance, Highway Safety Committee, Industrial Health Committee, Library Committee, Maternal Mortality Committee, and Board of Trustees.

\* \* \*

## COMMITTEE ON MEDICAL DEFENSE AND GRIEVANCE

Doctor Earl F. Kelly, chairman of the Committee on Medical Defense and Grievance, gave a brief oral report on the work of his Committee during the past year, and he also reported on a Medical-Legal Conference held in Washington and attended by the legal counsel of the Society, the president, the executive secretary, and himself.

## COMMITTEE ON INSURANCE FOR THE AGED

Doctor Alfred L. Potter discussed the report of the special committee appointed by the House of Delegates to investigate the possibility of a paid up at age 65 years health insurance plan under the Rhode Island Medical Society Physicians Service.

He reported that the Committee felt that in order to be useful its report must cover a larger area than was contemplated by the resolution.

The complete report was included in the handbook of the delegates and is made part of the official minutes of the meeting.

ACTION: It was moved that the House accept the report of the Committee. The motion was seconded and adopted.

\* \* \*

The report was discussed by members of the House of Delegates and the following motion was made:

That the House of Delegates approve the report of the special committee on insurance for the aged and refer it to the standing committee on Medical Economics with the request that that Committee report back to the House of Delegates at its September meeting procedures it would recommend for implementation of the suggestions noted in the report. The motion was seconded and adopted.

\* \* \*

A motion was made that the report of the Committee on Insurance for the Aged be given public release. The motion was seconded and adopted.

## CHAPIN HOSPITAL STUDY COMMITTEE

Doctor Hannibal Hamlin noted that the report of his committee had been included in the handbook of the delegates and is thereby made part of the official minutes of the meeting. He also distributed to the members of the House a copy of the report to the Joint Committee studying the future development of the Charles V. Chapin Hospital as prepared by Doctor Theodore H. Ingalls, professor of preventive medicine and epidemiology, University of Pennsylvania School of Medicine, in 1958.

ACTION: It was moved that the House of Delegates receive and accept the report of the Chapin Hospital Study Committee and that it commend the Committee for its excellent work. The motion was seconded and adopted.

## MATERNAL MORTALITY

The secretary noted that the report of the Maternal Mortality Committee was included in the handbook and was made part of the official minutes of the meeting.

ACTION: It was moved that the report of the Maternal Mortality Committee be accepted and that the president of the Society be authorized to appoint a Perinatal Mortality and Morbidity Committee, but the House does not at this time approve of any expenditure of Society funds for this Committee pending a further report from the Committee of the actual expenses it would incur. The motion was seconded and adopted.

*continued on page 396*



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## HOUSE OF DELEGATES

*continued from page 394***RESOLUTION REGARDING  
DOCTOR THOMAS PERRY, JR.**

The following resolution was presented and unanimously adopted by the House of Delegates:

WHEREAS Doctor Thomas Perry, Jr. has served this House of Delegates and the Rhode Island Medical Society with distinction for a period of seven years, and

WHEREAS in the discharge of his duties as secretary of this Society Doctor Perry has made a notable contribution to the progressive development and success of the Society and its programs, and

WHEREAS Doctor Perry now desires to be relieved of his duties as Secretary of the Society, therefore BE IT RESOLVED that this House of Delegates, assembled in meeting on this fifteenth day of April, 1959, record its appreciation and thanks to Doctor Perry for a job exceedingly well done for the Society and the Medical Profession of Rhode Island.

\* \* \*

Doctor Perry expressed his appreciation to the House for its expression.

**REPORT OF THE  
HEALTH INSURANCE COMMITTEE**

Doctor Robert C. Hayes, chairman of the Health Insurance Committee, discussed the Rhode Island Plan for prepaid medical-surgical insurance as sold by private insurance companies. He expressed the opinion that his Committee feels this Plan should not be continued.

There was general discussion of the subject.

ACTION: It was moved that the House of Delegates take no action on the Rhode Island Plan at this time. The motion was seconded and passed.

**TENURE OF OFFICE FOR  
CHAIRMEN AND OFFICIAL  
REPRESENTATIVES**

Doctor Stanley D. Simon presented a motion relative to the House taking action to establish a tenure system to prevail in the election of all standing committee chairmen and representatives of the Society.

After general discussion by members of the House, Doctor Simon withdrew the motion.

ACTION: It was moved that the House of Delegates authorize the president to appoint a committee to study and report to the House at its next meeting on suggestions for a tenure system in the election of standing committee chairmen and other official representatives of the Society. The motion was seconded and adopted.

\* \* \*

The suggestion was made that the president also secure advice of the legal counsel of the Society relative to certain phases of the Rhode Island Plan.

**ADJOURNMENT**

The meeting was adjourned at 10:45 P.M.

Respectfully submitted,

THOMAS PERRY, JR., M.D., *Secretary*

**REPORT OF THE SECRETARY**

At a meeting held since the January meeting of the House of Delegates, the Council took the following actions:

1. It received and reviewed a statement relative to a hearing and speech center at Rhode Island Hospital.
2. It approved of the action of the Group Professional Liability Insurance Committee in establishing a new malpractice program with the St. Paul Fire and Marine Insurance Company.
3. It recommended that the questions submitted by the American Medical Association relative to free choice of physician and closed panel system based on the report of the Commission on Medical Care Plans, be submitted to the House of Delegates.
4. It authorized the president to appoint a Science Fair Awards Committee, and it voted six awards, three to senior high school students, and three to junior high school students, for the best medical or public health displays as judged by the Society's committee.
5. It voted that physicians engaged in general practice of medicine may use the listing "General Practice" after their name in telephone or other public directories in any area in which such listing does not conflict with local district medical society regulations.
6. It authorized the president to submit the names of three members of the Society from whom one would be chosen by the Director of Health to serve as a member of the Committee of Consultants to the Board of Nurse Registration and Nursing Education.
7. It received notice from the mayor of Providence that the annual C. V. Chapin Award of the City would include an honorarium of \$200 to the Chapin Orator, instead of \$100 as previously given.
8. It received the audit report of the Ward, Fisher and Company of the Society's finances for 1958, with the information that in their opinion the records of the Society are carefully kept and are in proper detail to reflect its operations.
9. It authorized the Board of Trustees of the Medical Library to have the exterior of the

*continued on page 399*

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SQUIBB MULTIPLE VITAMIN SOFT TABLETS

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tablets that will  
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VIGRAN CHEWABLES *taste like candy*, but contain *no ingredients harmful to teeth*. Important, too, is that VIGRAN CHEWABLES *dissolve easily* in the mouth and *smell good*. These advantages will also appeal to your elderly patients. And VIGRAN CHEWABLES provide at least 125% of the minimum daily requirements for vitamins A, D, B<sub>1</sub>, B<sub>2</sub>, niacinamide and C, and significant amounts of other essential vitamins.

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Vitamin B <sub>2</sub> .....	3 mg.
Vitamin B <sub>6</sub> .....	2 mg.
Niacinamide .....	25 mg.
Calcium Pantothenate .....	3 mg.
Vitamin B <sub>12</sub> .....	5 mcg.

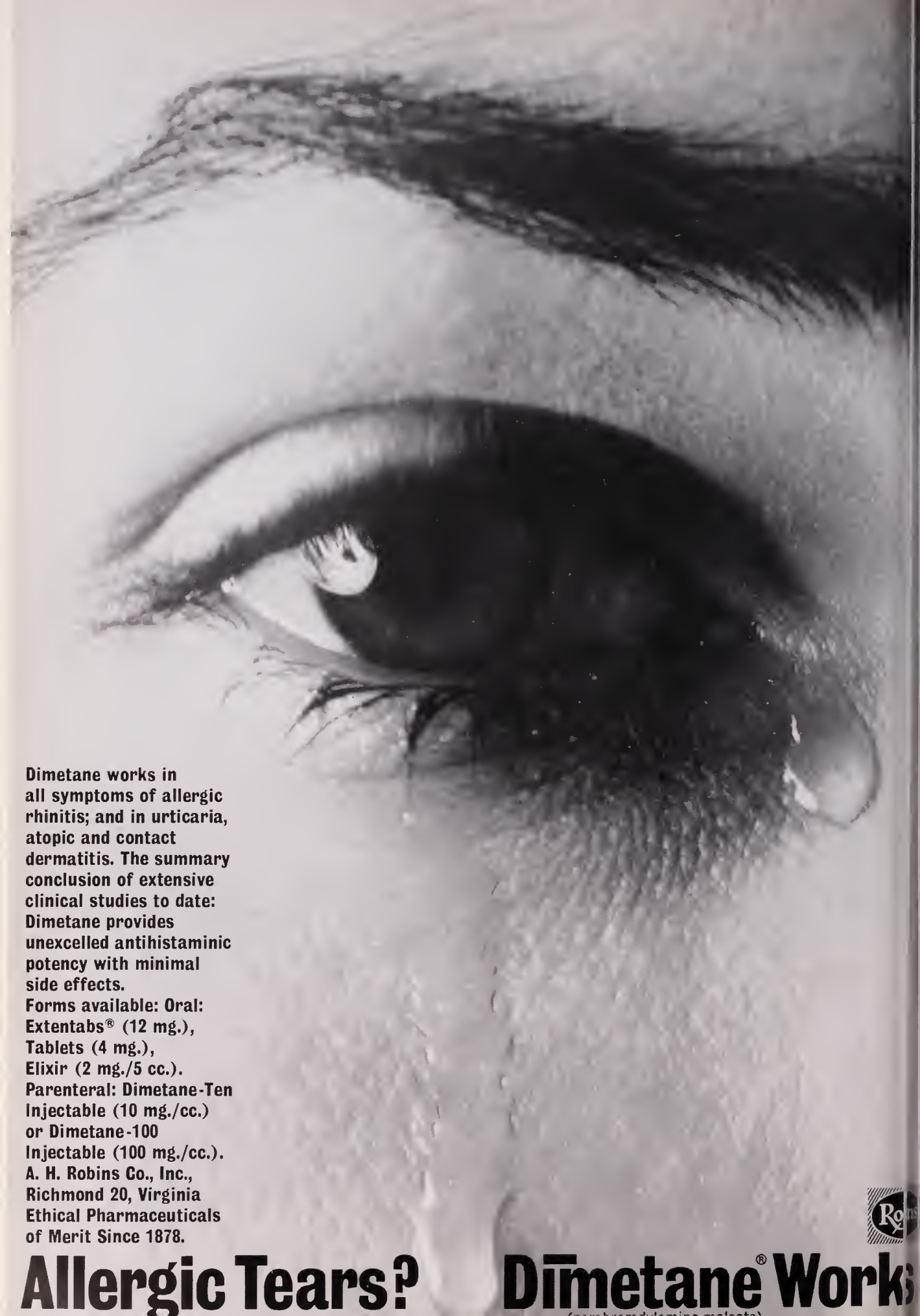
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of Merit Since 1878.

# Allergic Tears?

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## HOUSE OF DELEGATES

*continued from page 396*

Library Building painted, and the granite foundation sandblasted.

10. It approved the report of the Committee on Nominations of a slate of officers and standing committees to be submitted to the House of Delegates.
11. It authorized the president and the president-elect to establish a Sesquicentennial Celebration Committee for the Society's 150th year of existence to be noted in 1962.

THOMAS PERRY, JR., M.D., *Secretary*

## BENEVOLENCE FUND

During the year 1958, the Benevolence Fund received contributions in the amount of \$2,892.00. We are particularly appreciative of the contribution of \$300 from the Woman's Auxiliary to the Rhode Island Medical Society.

The trustees made awards to assist four physicians and their families with the total disbursements during the year amounting to \$2,116.40.

At the end of 1958 the fund had a cash balance of \$3,991.14, and contributions since that time have increased the fund so that the cash balance as of this date is \$7,286.14.

Members of the Society are again urged to notify the trustees of any physician in serious need so that assistance may be offered if necessary.

DAVID FREEDMAN, M.D.

GEORGE W. WATERMAN, M.D.

HENRY J. HANLEY, M.D.

## BLOOD BANK COMMITTEE

The present hospital system of blood banking in Rhode Island is satisfactorily meeting blood needs. There is still evident a steady trend upward in requirements for blood, in the complexity of processing techniques, in the necessity for community service and in one new area, that of providing group and type specific donors en masse for patients undergoing cardiac surgery.

In the technical area, all banks have profited from the growth of the AABB through its manuals on techniques and standards, the nation-wide reciprocity or Clearing House System, and in other phases of blood banking. All the major banks in Rhode Island are now institutional members of the AABB which means that the highly desirable and necessary features of uniformity of adequate standards of ethics, donor requirements, blood processing, handling and storage are being attained. These features assume increased importance with the growth of blood banking and provide a necessary foundation of mutual confidence to our local system of blood exchange upon need between hospitals. There has been favorable discussion on utilizing

the excellent AABB Inspection and Accreditation Program for member banks in Rhode Island, in place of developing and maintaining a local program.

The increasing public demand for (1) the nationwide transfer of blood and blood credits, and (2) Blood Assurance Programs is a healthy sign of recognition of the responsibility and importance of blood replacement.

The Rhode Island Hospital Blood Bank has, for two years, provided the opportunity for any and all residents of Rhode Island to receive and transfer blood and blood credits, from and/or to any other hospital in the country, through the AABB Clearing House System. This community service involves considerable expense which thus far the Rhode Island Hospital has been able to underwrite; how, when and where these expenses might have to be spread in the event of growth represents a potential problem.

Several banks are running Blood Assurance Programs for industrial and fraternal groups. However, it would appear that each bank will have to assume a greater share as the number of requests for these programs increases. This can be done at rather minimal expense to the hospitals, without adding employees, and without a great expense of time or effort, and represents an excellent source of blood. Actually, to a participating bank, the blood from these programs represents the only guaranteed supply in an area where day by day there is absolutely no control over either supply or demand.

Both of these public demands represent functions of community service and could perhaps be defined as outside the scope of any hospital blood bank, which technically has a primary responsibility only to the hospitalized patient. However, the Blood Bank directors within the state realize in general, that these demands must be met by our hospital Blood Bank System, since this system is preferential at the time to other systems for several reasons; it is medically supervised; it is functioning successfully, and it is under local control, although still providing opportunities for individual independence in certain areas. The preferential answer at present to the increasing requests for these programs would seem to be to absorb them into the present satisfactory hospital blood bank system through recognition, by each and every bank director, that for this system to survive, a proportionate element—with its cost—of this community service must be absorbed by each bank. Denying these public demands may well result in eventual clamor for establishment of some alternative to the hospital Blood Bank System. It would seem far more satisfactory for us to meet these demands in our own chosen manner and in good time, rather than to be forced into an alternative, perhaps medically un-

*continued on page 402*

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NEW  
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- combines the anti-inflammatory, antiallergic and antihistaminic effects of two agents—ARISTOCORT and chlorpheniramine which, separately, have been proved highly effective in the treatment of allergy
- permits greater latitude in adjusting dosage to minimum level needed for maintenance, because ARISTOCORT and chlorpheniramine are supplied in the lowest dose tablets available for each component alone
- supplies ascorbic acid for increased demand in stress conditions

*Indications:* Generalized pruritus of allergic origin; hay fever, allergic rhinitis, perennial asthma, seasonal and perennial rhinitis, vasomotor rhinitis; drug reactions and other allergic conditions.

*Dosage:* One to eight capsules a day in divided doses. Dosages should be established on the basis of individual therapeutic response.

*Precautions:* Drowsiness may occur, and is usually due to the antihistamine effect. Occasionally this may also cause vertigo, pruritus and urticaria. Because of the low dosage, side effects with ARISTOMIN have been relatively infrequent and minor in nature. However, since ARISTOCORT Triamcinolone is a highly potent glucocorticoid with profound metabolic effect, all precautions and contraindications traditional to cortico-

steroid therapy should be observed. Discontinuance of therapy must not be sudden after patients have been on steroids for prolonged periods. It must be carried out gradually over a period of as much as several weeks.

Further information available on request.

*Supply:* Each ARISTOMIN Capsule contains:

ARISTOCORT® Triamcinolone . . . . . 1 mg.  
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Ascorbic Acid . . . . . 75 mg.

Bottles of 30 and 100

*References:* 1. Maurer, M. L.: Clinical Report, cited with permission. 2. Levin, L.: Clinical Report, cited with permission. 3. Gaillard, G. E.: Clinical Report, cited with permission.

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comments by  
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*"I would conclude that ARISTOMIN is truly a worthwhile aid in treating allergic problems."<sup>1</sup>*

*"The results have been uniformly good. The patients have stated that their symptoms were very much relieved. I have not encountered any side reactions except from one patient, who complained of some drowsiness, which I attribute to the antihistamine."<sup>2</sup>*

*"In general . . . it [ARISTOMIN] is an excellent product. Over-all, it appears to be more effective than any simple antihistamine we have used. Despite the fact that we employed it in the treatment of a variety of nonselected individuals and problems, we had excellent and good results in 25 of the 39 patients."<sup>3</sup>*



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## HOUSE OF DELEGATES

*continued from page 399*

desirable system through influences outside the medical profession. It may also be wise at this time to begin consideration of courses of action to be taken if the hospital Blood Banks meet a saturation point with these programs. Within the next few years, normal and preferential growth probably would be into a medically and locally supervised community Blood Bank, which might function as an independent blood donor procurement agency for all hospitals of the state, absorb and run all the Blood Assurance Programs, and also draw the bulk of replacement donors from individual families for all hospitals.

In general, considering the rapid growth of this relatively young specialty, the present status of blood banking in Rhode Island is highly satisfactory. Continued effort will be necessary to maintain this status with tomorrow's trends.

ENOLD H. DAHLQUIST, JR., M.D., *Chairman*

## CANCER COMMITTEE

The Cancer Committee of the Rhode Island Medical Society has had two training programs dealing with cancer during the past year. One was a postgraduate training seminar for general practitioners, given on two successive Sundays, October 19 and 26. The other was the annual cancer sym-

## RHODE ISLAND MEDICAL JOURNAL

posium presented by a group from the Roswell Park Memorial Institute on March 18.

It is planned to repeat the postgraduate seminar and possibly expand the number of subjects covered. We shall have another Cancer Seminar next year.

HERBERT FANGER, M.D., *Chairman*

## CHAPIN HOSPITAL STUDY COMMITTEE

The report of the Chapin Hospital Study Committee was accepted at a previous meeting of the House of Delegates and placed on file. It is likely that none of the delegates has seen the report, and except for the newspaper coverage, would have had no opportunity to appraise the situation. Copies of the report are submitted herewith for the delegates.

The continued operation of Chapin Hospital has demonstrated its need to the whole community of Providence and the State of Rhode Island as indicated by the census statistics compiled for the past nine months. The administration and staff have voted to limit the hospital's services primarily to infectious disease and acute psychiatric illness. Both of these departments have maintained a high level of occupancy and turnover in the Richardson and East Wings, North and Hindle buildings. The cases cited in the census represent individuals who could not have been cared for at home or in other hospitals.

Acceptance of the Ingalls Report is only the first step toward implementation of its possible goals. The most important recommendation is that a closer working relationship between city and state agencies be developed in order to co-ordinate their respective health-hospital center functions effectively and economically. Chapin Hospital provides the physical space and opportunity for such co-operation. Here is the ideal location to plan a new and imperatively needed city health center subserving state administrative services as well. The advantages of contiguous housing for State Laboratories, Medical Examiner, Department of Welfare, and other agencies is clearly implied.

The House of Delegates can supply invaluable support for the attainment of aims envisaged in the Ingalls Report on Chapin Hospital toward the betterment of health facilities in Rhode Island and the Providence Plantations.

HANNIBAL HAMLIN, M.D., *Chairman*

## CHILD-SCHOOL HEALTH COMMITTEE

The activities of this committee have been limited this year. Our main recommendation is that, in line with the feeling of the American Academy of Pediatrics, we urge a fourth polio "shot" be given to all those who have had their third polio "shot" over nine months before this time. We, the Committee, strongly advise follow-ups on patients who



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JOHN T. BARRETT, M.D., *Chairman*

### DIABETES COMMITTEE

In view of the fact that the public has been widely informed in recent years on the importance of regular testing for diabetes, the Society's committee did not engage in the distribution of testing materials in connection with the 1958 annual campaign. The decision of the committee was also influenced by the fact that pharmaceutical companies have placed on the market at a low cost satisfactory self-testing kits for public use. Many large industrial companies have used such materials in the past year in connection with the annual diabetes detection campaign, with their industrial health personnel supervising the program.

The Society's committee did distribute several thousand leaflets and brochures, and hundreds of post cards to assist in publicizing the importance of a diabetes test. The state health department was also very active in the educational campaign.

A diabetes laymen's society is in the process of organization in the city of Providence, and this society of persons directly interested in diabetes may offer great help in the further control of the disease.

D. RICHARD BARONIAN, M.D., *Chairman*

### COMMITTEE ON GROUP PROFESSIONAL LIABILITY INSURANCE

In the fall of 1958 your Committee was notified by the Lumbermen's Mutual Casualty Insurance Company that it did not plan to renew the Society's group coverage which would be subject to renewal on May 1, 1959. This action came as a surprise to the Committee in view of the fact that the group's experience had been excellent since the coverage was initiated three years ago.

After careful review of proposals, the Committee accepted one submitted by the St. Paul Fire and Marine Insurance Company, to be administered locally by Starkweather & Shepley, Inc., of Providence. All members of the group were notified of the proposed change, and new applications have been filed for most of those covered under the group.

The Committee anticipates a better supervision of the new program by the local agents, and all members of the Society are urged to join the group plan as their individual liability contracts expire during the coming months. Members should check the date of expiration of their professional liability insurance, and make an application at least one month prior to that expiration date.

HENRY C. McDUFF, M.D., *Chairman*

*continued on next page*



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### HIGHWAY SAFETY COMMITTEE

During the year the members of the Highway Safety Committee have been alerted to various safety programs through mailing of notices and brochures from the executive office. The efforts of the committee to secure passage of the so-called Alcometer Bill by the General Assembly during the 1958 session proved of no avail. The measure had strong community support, but it was not brought to the floor of the Assembly for vote.

During the year 1958, the chairman of the Committee, Doctor Arthur E. O'Dea, who has done an outstanding job in the past three years in alerting both our own membership and the general public on the need for united action against traffic fatalities and accidents, moved his residence from Rhode Island. All of us will miss Doctor O'Dea's strong and able leadership.

The committee of physicians who volunteered to assist the Department of Motor Vehicles continues to function in an advisory capacity on medical problems of applicants seeking driving permits. This group of doctors warrants praise for their willingness to take on this task in the interest of the general public. The committee will continue to give advice to the Motor Vehicle Department whenever it is asked to do so.

The legislation—Senate Bill 4 and House Bill 1018—to allow the use of chemical tests for motor-

ists alleged to be driving under the influence of alcohol or narcotics, is again before the General Assembly. These model acts, sponsored by the State Highway Safety Council, offer a constructive step forward in the effort to protect life on our highways.

STANLEY FREEDMAN, M.D., *Chairman*

### INDUSTRIAL HEALTH COMMITTEE

The Industrial Health Committee of the Rhode Island Medical Society has for years represented the Society in its efforts to improve the medical programs relating to industry and employed workers in Rhode Island. The Committee is mindful of the efforts of the Society years ago to improve the workmen's compensation law, even to the extent of introducing legislation of its own writing. The Committee is also mindful of the many news stories published locally that were critical of the efforts of the physicians to co-operate in the operation of the state workmen's compensation program.

The Industrial Health Committee, as are all citizens, is concerned with the decrease in industrial activity in the state, and it is mindful of the cost of workmen's compensation insurance benefits as a factor in this industrial recession. Within the past two years the Committee has been deeply concerned with the awards in heart cases which it believes calls for intensive study and review if *employable* cardiac patients are to be rehabilitated and continued as gainfully employed citizens.

Recently the RHODE ISLAND MEDICAL JOURNAL editorialized on some of the vexing medical problems of our workmen's compensation situation. Undoubtedly these observations were based in part on the periodic reports of this Committee to the Society which have pointed out the seriousness of the problems, and the difficulty in securing support for a strong medical viewpoint on them in the community.

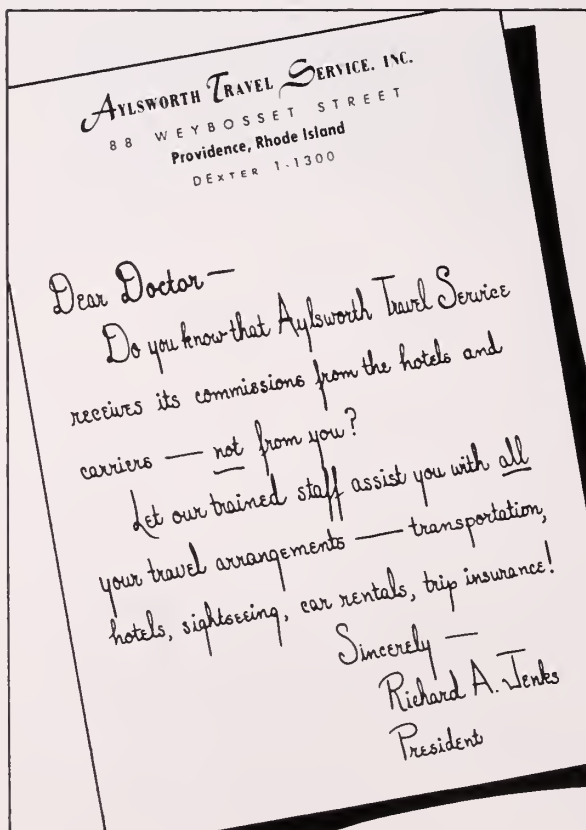
The Committee, therefore, makes the following observations:

#### 1. *Compensation for hernia.*

By legal ruling all hernias have become compensable. The Rhode Island law makes no provision for establishing criteria for compensable hernia, and we believe that such criteria should be stated in the law, or established by administrative regulation.

We maintain that in all claims for compensation for hernia resulting from personal injury received in the course of and resulting from the employee's employment, it should be definitely proved to the satisfaction of the Commission that—

- a) There was an injury resulting in hernia;
- b) It is reported to the employer within 48 hours after its occurrence (Sundays and holidays excluded);
- c) The hernia appeared suddenly;





- d) It was accompanied by pain;
- e) It immediately followed an injury;
- f) It did not exist prior to the injury for which compensation is claimed.

## 2. *Adjudication of Cardiac Cases.*

Work is important for health, and for that reason alone physicians are extremely interested in the problem of employment for the cardiac patients. We believe that heart disease and industry are not incompatible. We, therefore, are greatly concerned that heart cases become compensable by legal ruling. In our opinion exhaustive study and review of each individual case by expert impartial medical testimony must be continually sought if the interests of all workers is to be protected.

Studies and surveys have clearly indicated that work *per se* does not produce heart disease. Coronary atherosclerosis or some other form of coronary disease must have pre-existed in an individual who suffers a coronary occlusion and myocardial infarction.

It has also been demonstrated medically that performance of the same type of moderately heavy work without engaging in unusual exertion or strain has no injurious effect upon the heart. In fact, a myocardial infarction occurring during such work is not causally related to the employment, and subsequent attacks of myocardial infarction are not necessarily causally related to the first attack, but rather to the underlying pathology of the coronary vessels of the heart. In general, the emotional factor probably plays a more important role in bringing on such an attack than the physical.

We, therefore, are of the opinion that the Workmen's Compensation Commission should utilize the services of cardiologists as impartial experts in seeking advice in any case where there may be the slightest doubt in the mind of the hearing officer as to the validity of the presented medical testimony of the claimant.

We advance this proposal not in the interest of any financial saving to industry, but rather as an honest conviction voiced in the interest of the worker who is still employable, and who should be gainfully at work in spite of a cardiac condition, but who will be denied employment by industry because the compensable risk involved is too great.

## 3. *Back Injury Cases.*

Injuries to the back, like headaches, cannot always be clinically proved. They present a particularly vexing problem for the physician when the claim is based on employment and compensation is sought. The Rhode Island Medical Society advocated to the General Assembly in 1953 that a special report concerning industrial cases involving back injury be drafted, and in 1954 when the workmen's compensation law was revised the Society sought

and obtained the inclusion of the medical provision that

"Every physician treating any employee pursuant to this chapter shall, when the injury for which the employee is being treated involves an injury to his back which causes the loss of time for more than 7 days, file with the director of labor within 14 days after the first examination of the employee by the physician, a special report concerning such back injury. The director of labor, with the advice of the medical advisory committee, shall have the authority to prescribe the form of such special report, and may recommend specific tests to be performed in the diagnosis and treatment of such back injury with the recommendation and approval of the employee's physician."

To our best knowledge this provision has never been implemented. On the contrary, workers have been reported to have received lump sum settlements from one or more different employers for the same or a related back injury, and no special report or tests, as recommended in the statute, have been carried out.

We believe that this provision in the law should be implemented to provide the necessary legal mechanisms to allow definite action to be taken on such back reports in order to eliminate repeat lump sum compensation payments.

## 4. *Annual Examination of Totally Disabled Cases.*

The Committee on Industrial Health supported the inclusion in the law of the provisions that every case of total disability or severe permanent partial disability on which compensation has been paid for a period of one year shall be re-examined by the director of labor and such action taken as in the judgment of the director and the Commission, with the advice of the medical advisory committee, shall seem practicable and likely to speed the recovery and rehabilitation.

This phase of the law should be carried out as enacted by the General Assembly.

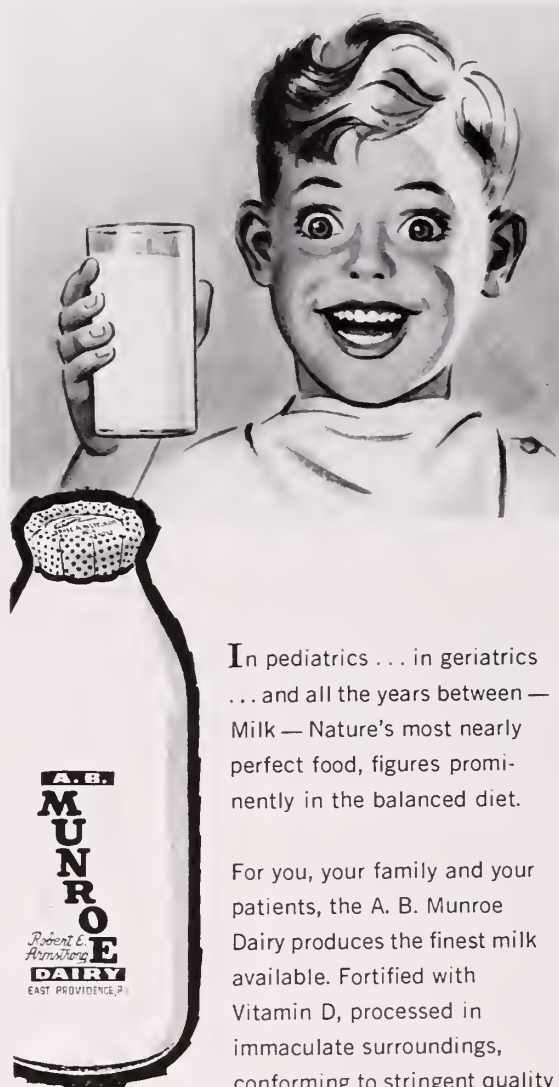
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## 5. Medical Director as Member of the Commission.

The Committee on Industrial Health maintains, as it has in behalf of the Society for years, that a full-time medical director should be included as a member of the Workmen's Compensation Commission. The program is based entirely on personal injury or illness sustained by an employee arising out of and in the course of his employment. Thus, expert medical advice is of paramount importance at all times. We believe the Commission would function more effectively in the interests of the employed worker, as well as for industry, if a doctor of medicine with experience particularly in industrial medical problems, had full-time commissioner status, sitting with the other commissioners as a body on any case, or with any one commissioner in the adjudication of a claim.

\* \* \*

The Committee on Industrial Health of the Rhode Island Medical Society acts entirely in the interest of the employed worker, the direct beneficiary of the entire program, and its intention is not to point undue criticism to the state department of labor or the Workmen's Compensation Commission.

The Society and its committees have always been ready and available to assist any public or private agency in the operation and administration of medical phases of a program which has as its specific purpose the improvement of the health and welfare of the citizens of the state. The Department of Labor through the years has been most considerate of this attitude of the Medical Society and its Industrial Health Committee.

Some of our criticisms may run counter to legal interpretations of the present law, and we do not presume to qualify on that problem. We are directly concerned with better medical supervision of the program.

Criticism, however, objective, is never popularly received. Emotional outbursts often ensue to cloud the basic issues presented. We sincerely hope that the suggestions and recommendations advanced in this report will be accepted in the honest spirit in which they are presented.

STANLEY SPRAGUE, M.D., *Chairman*

## LIBRARY COMMITTEE

The librarian and her staff have, at long last, tackled the mixed up, dusty, dilapidated, unbound journals on the third floor. It became necessary when the old accession book, dating from Doctor Hersey's time and containing the only list of most of the material stored there, disintegrated almost completely. The few journals that were catalogued were in such disorder that the staff needed a map



to find them. So, armed with smocks, gloves, head coverings, nose masks (and, during the winter, double sweaters and knee socks) and a Hoover Pixie vacuum, two members of the staff plunged in. They are happy to report that most of the sorting, dusting and preliminary listing has been done and the journals will be ready for re-shelving in a few weeks. The next project will be the second floor, where the textbooks, though catalogued, are in great disorder. If all goes well, the stacks will be in order by the end of October, in time for the meeting of the New England Regional Medical Librarians which is being held in our building, and we'll be proud instead of ashamed to show visitors our collection.

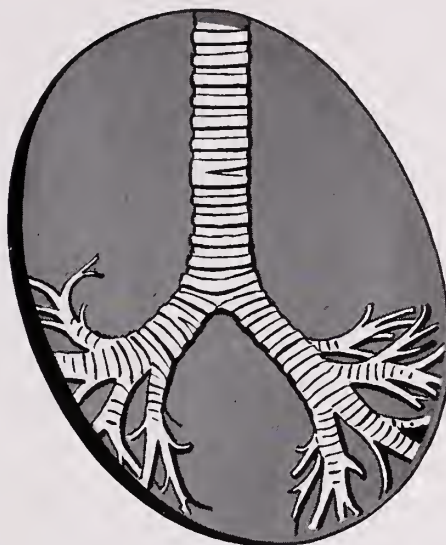
We were happy to be in the position of helping two libraries increase their holdings by sending them material from our large collection of duplicates. One hundred sixty-nine journals were sent to the Westchester Academy Medical Library and 104 bound volumes and 884 single issues were sent to the University of Kentucky Medical Center Library. We offered 173 journals through the Medical Library Association Exchange. There will be room in the storeroom now for the duplicates we're finding on the third floor. All shipping charges are, of course, paid by the library requesting the duplicate material.

The librarian attended the first meeting of the New England Regional Medical Librarians, held in Boston on December 5, 6, 1958. The sessions were held at the Boston Medical Library and the Harvard Medical School and the discussions included the subjects of Interlibrary Loan and Serials Work. It was an interesting and informative meeting.

Doctor Stanley S. Freedman has contributed to the appearance of the Reading Room by having the library clock cleaned, overhauled, polished and re-gilded. And our many other friends of the library have been generous with gifts of books and journals. These gifts are noted in *On the Medical Library Bookshelves* throughout the year but we wish to thank them again for their contributions.

Statistics for April 9, 1958, to April 1, 1959: We have added 181 bound volumes (209 were received but the duplicates were discarded) to our collection, making a total of 42,433. Our readers numbered 1,941, of whom 1,166 were physicians and 775 general public. Circulation included 1,591 periodicals and 426 books; of these 80 were borrowed from the Davenport Collection. We are happy to see that circulation of the books in this collection is increasing and wish to call the attention of the Fellows to the fact that they may borrow these nonmedical texts by medical men and that we add new titles each year. We borrowed eleven items through our interlibrary loan and loaned 586 to other libraries in Rhode Island and Massachusetts.

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The last figure indicates our importance as a repository library where smaller libraries may call for material not on their shelves. Two hundred and nineteen bibliographies were prepared. We are receiving 406 periodicals currently; 97 volumes of journals have been bound and 39 are being processed at the present time. Through the Medical Library Association Exchange, we have been fortunate in acquiring 19 single journals (completing 4 volumes) and 2 bound volumes of the early ARCHIVES OF NEUROLOGY AND PSYCHIATRY which we lacked. Cataloguing is proceeding slowly with 31,486 bound volumes and 3,919 unbound volumes and pamphlets completed.

The Committee wishes to express its sincere appreciation of the devoted service which has been rendered during the past year, as in previous years, by the staff, consisting of Mrs. Helen DeJong, librarian; Miss Grace Dickerman, librarian emerita, and Mrs. Joann Watson, assistant librarian.

IRVING A. BECK, M.D., *Chairman*

### MATERNAL MORTALITY

*Subject:* Report on the proposed formation of a Perinatal Mortality and Morbidity Committee for the Rhode Island State Medical Society.

*From:* the Sub-Committee of the Maternal Mortality Committee of the Rhode Island Medical Society.

*To:* the Chairman of the Maternal Mortality Committee, Rhode Island Medical Society.

Date of Meeting: February 17, 1959

Committee Members: *Chairman*, Dr. Bertram H. Buxton, Jr.; Doctors William J. MacDonald; William A. Reid, and George Anderson.

Invited Participants: Dr. Eric Denhoff and Dr. Herbert Ebner.

The Subcommittee unanimously agreed that there existed an urgent need for the formation of a Perinatal Mortality and Morbidity Committee of the Rhode Island Medical Society. Beyond the fundamental and idealistic objective of contributing to the ultimate goal of a normally developed and emotionally well-adjusted child for each conception are more immediate reasons. These include a means of educating patients, physicians and nurses, the improvement of physical, emotional and social environments of pregnancy and the improvement of the physical facilities in which the infant is born and subsequently cared for. Finally, it is obvious that such a committee, through its investigations and studies might identify needs for further investigation and research, particularly in this state, where geographical compactness lends itself well to case findings and complete follow-ups.

The objective of such a committee, generally, would be that proposed in the supplementary report

of the council on Medical Education of the American Medical Association, titled, *A Guide for the Study of Perinatal Mortality and Morbidity*. This general objective of a Perinatal Mortality and Morbidity Committee should be to improve the production of normal human beings by eliminating deaths and damage during the reproductive process. In achieving this goal, all individuals and committees should rigidly and courteously adhere to scientific and ethical principals.

A specific objective of this committee should include, at the outset, the adoption of uniform terms and definitions and rates for all perinatal deaths occurring within the State of Rhode Island, in conformance with the recommendations of the American Medical Association Committee of Maternal and Child Care. This will facilitate national and international comparison.

A main objective and function of the State Perinatal Mortality and Morbidity Committee should be to entice, urge, support and help develop the formation of hospital perinatal mortality and morbidity committees throughout the state in hospitals where obstetrics is practiced. The Committee agrees that this can be done only through vigorous and enthusiastic campaigning and education, and recognizes that through its State Medical Journal, this Committee may secure and obtain the co-operative action on the part of all hospitals and obstetric and newborn units in the state.

A further objective of this Committee would be to form a strong liaison with the Rhode Island Department of Health, not only in standardizing terms and definitions, but eliciting their support and close co-operation in obtaining accurate data from the various hospitals throughout the state. Without such strong co-operation between this Committee and the State Department of Health, the program would be ineffective.

The function of this Committee would be one primarily of co-ordination and processing of data, the institution of uniform reporting of all perinatal mortalities and the preparation of reports and special articles for publication in the state medical journal. It is probable in the initial year of this Committee's formation that specific case findings and processing of total data would not be feasible, since groundwork on the development of Hospital Perinatal Mortality and Morbidity Committees would only have just begun. However, basic tables of perinatal mortality split into neonatal and fetal deaths in 500 gram increments would be a decided improvement over the past lack of uniformity in reporting such data and it feels the Committee can entertain and undertake a special report in its first year of origin on some such subject as perinatal mortality in Caesarean section, for example.

*concluded on page 410*

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## HOUSE OF DELEGATES

*concluded from page 408*

This Subcommittee feels that the personnel of such a Committee should include obstetricians and pediatricians from the various hospitals in the state wherein obstetrics is done. It recommends the naming of an anesthetist who is familiar where obstetric anesthesia and resuscitation of the newborn, as well as a pathologist who has interest, as well as the background and experience in neonatal physiology. The personnel of this Committee should also include the director of Health of the State of Rhode Island or his designate, as well as the director in the State of Maternal and Child Health. A member of the State Department of Health Statistical Department should be included and as the Committee's concern in this important field grows the recommendations of the A.M.A.'s report on Perinatal Mortality and Morbidity Committee should be observed by the inclusion of members of the nursing profession and personnel from the social welfare agencies in the state.

The costs arising from the expense of such a Committee for staff personnel, bookkeeping, supplies and travel should be met from the treasury of the Rhode Island Medical Society and/or from the State Health Department.

The Subcommittee further recommends that a specific meeting place, such as the Rhode Island

## RHODE ISLAND MEDICAL JOURNAL

Medical Library, be chosen and that meetings be scheduled at least monthly. The Subcommittee feels that it should leave to the Committee, once established, the design and inception of a uniform data sheet for the recording of pertinent items in connection with any case of perinatal mortality.

In summary then, this Committee recommends to the chairman of the Maternal Mortality Committee that he recommend in turn to the president of the Medical Society that a Perinatal Mortality and Morbidity Committee of the State Medical Society be formed and submit to said president sufficient specific recommendations to enable the president of the Medical Society to name a Perinatal Mortality and Morbidity Committee, which will possess the necessary qualifications, enthusiasm and perspective to make this committee as effective as possible, as early as possible.

BERTRAM BUNTON, JR., M.D., *Chairman*

## BOARD OF TRUSTEES OF THE MEDICAL LIBRARY

The extensive repairs and additions provided in 1957 and 1958 have put the Medical Library building in excellent condition, and have also provided better facilities for the members, the public, and for the employees of both the Society and the Medical Bureau of the Providence Medical Association.

The trustees have noted for some time the discoloration of the granite foundations as the result of rust drippings from the iron balconies on the second floor. The Council recently authorized the trustees to have the foundation and the granite entrance steps, the platforms and limestone columns, sand-blasted. We feel certain this will restore to the lower exterior of the building its former beauty. If this work proves as satisfactory as we hope, then the cornice sills, lintels and capstones may be cleaned later in the year by the same method.

In addition, the trustees have been authorized to contract for the painting of the exterior of the Library, and this work should be completed in the month of April.

As has been noted before, the Medical Library building is an asset that probably is not fully appreciated by all our Society membership. Exclusive of contents, or the land on which it is located, the Library building replacement value is over a quarter of a million dollars.

Visitors from other states have been high in their praise of our Library and its facilities, and we are indeed indebted to the members of the Rhode Island Medical Society who contributed to make the building possible in 1912. We all have an obligation to keep the building in excellent physical condition, and we all have reason to be proud of the fact that our own membership maintains one of the finest medical libraries in the nation.

SAMUEL ADELSON, M.D., *Chairman*

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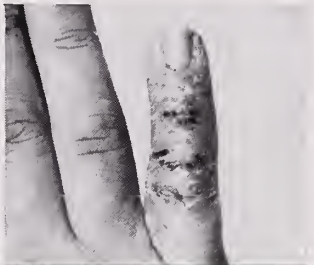
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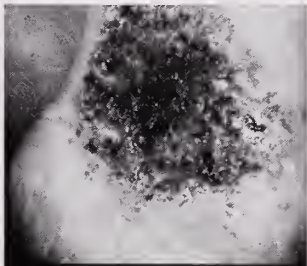
**References:** 1. Shelmire, J.B., Jr.: *Monographs on Therapy* 3:164 (Nov.) 1958. • 2. Nix, T.E., Jr., and Derbes, V.J.: *Monographs on Therapy* 3:123 (Nov.) 1958. • 3. Robinson, R.C.V.: *Bull. School of Med., U. Maryland* 43:54 (July) 1958. • 4. Sternberg, T.H.: *Newcomer, V.D., and Reisner, R.M.: Monographs on Therapy* 3:115 (Nov.) 1958. • 5. Clark, R.F., and Hallett, J.J.: *Monographs on Therapy*, 3:153 (Nov.) 1958. • 6. Smith J.G., Jr., Zawisza, R.J., and Blank, H.: *Monographs on Therapy*, 3:111 (Nov.) 1958. • 7. *Monographs on Therapy*, 3:137 (Nov.) 1958. • 8. Howell, C.M., Jr.: *North Carolina M.J.* 19:449 (Oct.) 1958. • 9. Bereston, E.S.: *South. M.J.* 50:547 (April) 1957. And whatever the topical corticoid need, a suitable Squibb formulation is available—Kenalog-S Lotion—7½ cc. plastic squeeze bottles. Each cc. supplies 1.0 mg. (0.1%) triamcinolone acetonide, 2.5 mg. neomycin base and 0.25 mg. gramicidin. **Kenalog Cream**, 0.1%—5 Gm. and 15 Gm. tubes. **Kenalog Lotion**, 0.1%—15 cc. plastic squeeze bottles. **Kenalog Ointment**, 0.1%—5 Gm. and 15 Gm. tubes.



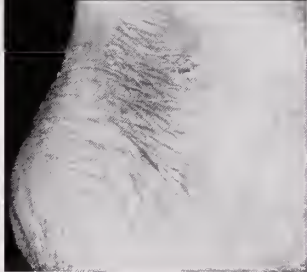
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## REPORT OF THE COMMITTEE ON INSURANCE FOR OLDER AGE PERSONS

Submitted to the House of Delegates, April 15, 1959

THE House of Delegates in September, 1958, established a special committee "to investigate the possibility of a paid-up at age 65 years health insurance plan under the Rhode Island Medical Society Physicians' Service Plan from the following points of view:

1. Its effectiveness as a specific measure to combat governmental health plans for the aged.
2. Its financial feasibility, and
3. Its public acceptance.

The committee would report to the House of Delegates within six months.

The committee feels that in order to be useful, its report must cover a larger area than was contemplated by the resolution.

Your committee feels that the average American citizen prefers the voluntary way of meeting his personal problems as opposed to subjection to governmental supervision. We believe that a voluntary medical care plan will be welcomed by the public rather than a government controlled and tax supported program. We believe that the problem has been exaggerated by those using it for political reasons and that the existing means for its relief are minimized. That there is a problem, and always will be, is obvious, but we believe that it can be better taken care of by existing agencies than by turning to the Federal government in Washington.

To get a proper perspective on the problem of health care of the elderly, or the citizen over 65 as some prefer the classification, here are some considerations:

1. People now live longer. There are more people over 65 than ever before, and their numbers are increasing. There were 15,000,000 in the United States last year, 1 in 10 of our population. It is quite certain that by 1980 there will be 1 in 11, or 25,000,000 over 65.

2. With increasing age there is increased use of doctors' and hospital services, more for this group than any except infants. Hospital use by the aged is 21%, as contrasted with 11% for all ages. In addition to increased incidence of use, the elderly have a longer stay in hospital, and a higher usage of specialists.

3. After 65 unemployment drops off sharply, and with retirement comes diminished income. As

many of these persons have had some form of insurance paid for wholly or in part by their employers, as fringe benefits and not part of their "take-home pay," they are not used to paying for insurance out of their pocket. They are not insurance-minded, and in many cases drop their coverage even when the insurer might be willing to continue the policy.

4. Even when the policy may be continued, many face increased rates or diminishing benefits, making its continuance unattractive.

Hence at an age when their need for health care is increasing, the ability of many of the over 65 to carry insurance, or even its availability, becomes reduced.

The Committee on Aging of the American Medical Association which has been thoroughly going into this and allied problems urged last fall:

1. Promote among the general population a realistic attitude toward aging and the importance of preparation for senior citizenship. (Here your committee would put that into plain English: We are all getting older. Every man will die some day, sooner or later. Every man will have a terminal illness of long or short duration, and before that time he will begin to wear out.)

2. Develop effective methods of financing health care for the aged primarily through voluntary health insurance prepayment plans, and secondly, for the indigent, through community or state aid.

3. Provide increased facilities for the aged through the Hill-Burton Act by building nursing homes and chronic disease units.

4. Health maintenance programs, morale builders, etc.

In discussing "health care" it is only fair to both the doctors and the hospitals to consider "doctors' bills" and hospital bills separately. For years the patient has used the term "doctors' bills" to express the total cost of his illness or operation. When hospitals were a last resort, a place to go to die, and when the cost of hospitalization was relatively low, the total cost was not too far out of line. The American consumer, according to the Department of Commerce, now spends proportionately more of his dollar for various medical services, health insurance, hospitals, ophthalmic care, orthopedic appli-

*continued on page 414*



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1. Litchfield, H. R.: Archives Pediatrics 74:463, 1957

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## INSURANCE FOR OLDER AGE PERSONS

*continued from page 412*

ances, and doctors than he did ten or twenty years ago. The quality of these services has improved and the quantity is available for his larger outlay. Medical care is now a part of his family budget.

In 1929, thirty years ago, the Commerce Department gave three billion dollars as the aggregate cost of medical care. By 1957 this total was fifteen billion. This five times increase was in part due to population increase, but on a per capita basis rose from \$24 to \$89. By relation to consumer price index this was 32 in 1929 and 65 in 1957, about double. However, the disposable personal income per capita (after taxes) rose from \$683 in 1929 to \$1,812 in 1957, triple in amount.

The physicians' share of the dollar spent for medical care has dropped from 33 cents in 1929 to 24.5 cents in 1957.

The cost of hospitalization has necessarily soared and is now increasing at better than 5% a year. Actual "doctors' bills" for years have been at a relative standstill.

The American consumer has become habituated to spending more of his increased income for medical care as part of his increased standard of living and is aware of the value of good medical care. He is willing to pay for it when he can. He now pays 1.3% of his income for doctors as opposed to 3.2 for alcoholic beverages, as compared with 1.2% and 5.2% in 1947, and almost as much for total medical care (5.3%) as for recreation (5.6%).

For our discussion only one of the three groups into which we may divide the elderly concerns this report.

1. There are those who have been able to save for their old age or have financial means so that their health care is no great problem.

2. There are the indigent, whom we have always had with us; the unfortunate who, not through their own improvidence, have been overwhelmed by catastrophic illness; and the thriftless, and society's misfits whom we must care for.

It seems to your committee that these latter groups can be best cared for by their own community or state. (Our hospitals cannot long go on caring for this group below cost, either through the increased cost to other patients by increased rates, or by continued deficits of the hospitals.) We might suggest here that this group need not be segregated as far as health care if the local government were to insure these indigents, making available the care their fellows enjoy. Such plans would require no duplication by a new bureaucracy to collect taxes and redistribute them throughout our country, but leaves our present well-functioning plans to continue to explore and develop as they are doing. Our Blue Cross-Physicians Service, nonprofit making

community organizations, seems ideal for this function.

3. There is left for our discussion the elderly who are turned out to pasture after a lifetime of work during which they have been protected by sick benefits from employer and probably by fringe benefits in some form of health insurance, private or Blue Cross-Physicians Service. With retirement their fringe benefits stop, their income drops, and they are an undesirable group from the "experience rating" insurance standpoint. A survey in 1957 showed that 3 of 8 over 65 had some form of voluntary health insurance, 1 of 6 had carried it up to five years ago, 2 of 3 said they would like insurance to cover all expenses, and 3 of 5 were either not insured, had it formerly, had been rejected, or never tried to get it.

Our Rhode Island Blue Cross-Physicians Service covers the over 65 age group under the same rates as before reaching this age, using the community rating policy, but it can be seen that this puts these Plans at a disadvantage in competition for group contracts with a private insurance company whose cost to an employer is based on an experience rating of a group of young and middle-aged men. Also at the time of retirement the insured is no longer to be carried on a group contract; he is up rated, given lesser benefits, or even urged then to transfer to the Blue Cross-Physicians Service. The administrative cost of the individual as compared with the group policy is about double.

Physicians Service and Blue Cross are nonprofit organizations, but to give the benefits to their policyholders as contracted, they must by law keep solvent, maintain the required reserves, and conform to the requirements properly insisted upon by the Commissioner of Insurance. Up to this point the Plans are public benefactors. Some insurance commissioners frown upon one insured group of the population being subsidized by the other carriers. Throughout the nation the Blue Cross and Blue Shield Plans have not been as considerate of the elderly as have been our Rhode Island Plans. Many states urged by the American Medical Association in the past few months are changing this attitude, and there are also now more policies being offered by private companies designed for the elderly, but none can be compared favorably with our Rhode Island Plans. This is not new. In rates and in economy of operation the Rhode Island Plans have always been outstanding.

The executive director of the Blue Cross-Physicians Service reported recently that "of the more than 70,000 people in the state who are over the age 65, approximately 56,500 are enrolled in Blue Cross and 41,000 are enrolled in Physicians Service" and right now "we have over 400 people between the ages of 90 and 99 enrolled in Blue Cross and over

300 in Physicians Service. In addition, there are more than 5,000 between the ages of 80 and 89 in Blue Cross and nearly 4,000 in Physicians Service." Our plans, then, allow subscribers to continue as members regardless of age, and with no reduced benefits.

All prepaid health insurance is relatively new, and insurance for the aged has little experience on which to base its rates. There must be trial and experiment. All over our country there are groups studying the problem, trying various plans which best suit local conditions. There are plans for complete coverage, such as the Windsor, Ontario, plan, which is apparently satisfactory there; there are plans to include care in the home; plans with or without deductible features. Until the evidence is in we must await the verdict.

As doctors we cannot directly control hospital costs, which are by far the heaviest expense. We can keep down unnecessary admissions; we could do more by having many diagnostic procedures done before admission. Such a plan requires changes in Blue Cross regulations covering laboratory and other costs of diagnosis done outside the hospital.

The one thing we can do as a group of doctors is to continue to do what we as a profession have done always, care for the needy and those whose income level deserves our consideration by accepting payment for services according to the income level. This is Physicians Service (the doctors' own plan) and your committee feels that a doctor who does not join and bear his share of this obligation is not doing his duty. Under it there has never been an increase in rates or decrease in services and benefits directed at those over 65, and as their income drops their cost for a surgical operation is completely covered.

The question of prepaid insurance other than on an annual basis seems unanswerable. During his productive years a man may and can, by one of the many forms of insurance available, set up a fund to draw upon at sixty-five or any age desired for future illness care. But no actuary can reasonably foretell from past costs, or prophesy of the future value of the dollar, what future medical costs will be. Hospital costs now rise better than 5% a year. Only an indemnity form of insurance paying so much a year toward some future illness in 1965 or 1980 could be written. Suggestion is made that the worker might set aside a yearly sum tax-free during his productive years to enable him to care for his health in his old age. This would seem to your committee too sensible, smacking too much of old-fashioned thrift, to find acceptance by those who want these things done by a beneficent government. An employer can hardly be expected to do this. The

younger employees may properly object to contribute for their elders by a decrease in their take-home pay, unless human nature changes. Even the Federal government with its vast social security system providing old age and survivors "insurance," so-called, does not attempt to guarantee anything but a cash indemnity. The Social Security System promises a cash indemnity at the age of 65, but it gives no assurance that this indemnity to be paid at some future date will have the same purchasing power that it has today; and further, it retains the right to alter at any time the premium charge (taxes) to be imposed on the compulsory "contributor." Hence a prepaid insurance to cover the health needs in the future, without changing the rules as time goes by is impossible.

We believe that the physicians of Rhode Island, through their voluntary Physicians Service Program, will continue to seek ways to aid all persons, and particularly the older aged group for whom there is so much concern lately. We offer the following suggestions as possible avenues to be followed in the expansion of benefits for the over 65 age persons:

1. The physicians of Rhode Island have always been willing, of their own initiative, to accept a reduced fee, or no fee, for home or office visits for older aged persons with limited financial resources. As was attested in a recent appraisal of the financial operations of the state government, physicians in the state gave over a half million dollars of free service in the fiscal year 1956-57 to public assistance recipients, many of whom were undoubtedly over 65. We suggest, however, that the House of Delegates of the Society consider the advisability of exploring a possible reduced fee schedule for home and office visits for persons over 65 whose annual income is the same as Physicians Service income limits.

2. We suggest that the House of Delegates urge that management and labor explore the possibility and feasibility of the continuance of Blue Cross and Physicians Service coverage for all employees upon their retirement after a stipulated term of service with a given employer, the premium to be paid by the employer, or jointly by the employer and employee for comprehensive plan coverage.

3. We suggest that the Blue Cross explore with hospital administrators and boards of hospital trustees the possibility of an insurance that would provide hospital expenses for the elderly at a special premium rate, such as is currently being developed in Iowa.

4. We suggest that the House of Delegates urge upon the insurance industry, through its national associations, the elimination of health and accident insurance cancellations because of age.

*concluded on next page*



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5. We urge co-operation by the public, by our political representatives, and by our newspapers in solving this problem wisely, and not impulsively by hasty action.

Once we turn down a wrong road the return may be difficult or impossible. We doctors hear no loud clamor for the grocers to cut their prices for the elderly, or for landlords to lower their rents for those over 65, but, although the public has been told on the highest authority that every citizen is entitled to be well-clothed, well-housed, and well-fed, only the doctors have and will continue to adjust their charges below their fair and usual fee for service through their Physicians Service plan and as far as possible through the Blue Cross to which it is allied.

6. In conclusion we would point out that while medicine will do its part to bring about continued improvements in voluntary health insurance programs, we must have equally strong support from employers, labor organizations, insurance companies, and the people themselves. We believe that society has the responsibility to provide necessities, of which medical care is only one, to those persons who are unable to provide for themselves.

We are convinced that the people requiring such assistance are a small portion of the total in any age group, and our common efforts must be directed toward developing programs for keeping elderly people well and productive through proper health maintenance and proper living. A healthy, elderly person, with the assistance of voluntary prepayment health plans, will not only be in a position to purchase a major portion of his medical care needs, but, in our opinion, he will want to do so because of the maturity and wisdom through living experience that has given him his increased years of life.

### *Committee to Study Paid-up Health Insurance at Age 65*

ALFRED POTTER, M.D., *Chairman*

ERNEST K. LANDSTEINER, M.D.

JOHN F. GILMAN, M.D.

ALEXANDER A. JAWORSKI, M.D.

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WILFRED TROTTER, F.R.S.  
*Collected Papers*

## CHECK THE POSTAGE ON LABORATORY SPECIMENS

The Rhode Island Department of Health has been notified by Mr. R. A. Creegan, postmaster of Providence, that first-class postage will be required on all laboratory specimen containers furnished by the state laboratory. This includes containers for specimens for blood chemistry, throat cultures, sputum for TB, fecal examinations, blood serology, and smears for Neisserian infections.

Mailing containers are being held up at the post office when insufficient postage is attached and the proper amount due determined prior to delivery to the laboratory. Physicians, or persons submitting specimens for reporting to physicians, should bring the containers to a post office for weighing to determine the correct amount of postage required.

Since this is a service to the physicians, the Department of Health does not supply the postage.

Check the Date . . .

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JULY, 1959

## *Medical Journal*

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Table of Contents, page 431

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Increased incidence of staphylococcal infections has been reported for Europe, Britain, Australia, New Zealand, and the Americas.<sup>1-5</sup> World-wide reports indicate that many strains responsible for these infections are resistant to commonly used antibiotics.<sup>1-3,5-14</sup> However, this ubiquitous pathogen, according to studies from Germany,<sup>8</sup> Canada,<sup>9</sup> Uganda,<sup>10</sup> New Zealand,<sup>11</sup> England,<sup>12</sup> and the United States,<sup>13,14</sup> remains sensitive to CHLOROMYCETIN. CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in a variety of forms, including Keflin of 250 mg., in bottles of 16 and 100.

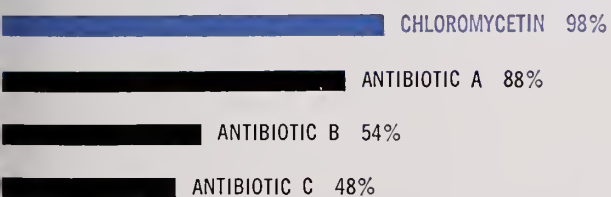
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**REFERENCES:** (1) Smith, I. M.: Staphylococcal Infections, Chicago, Year Book Publishers, Inc., 1958, p. 21. (2) Pryles, C. V.: *M. J. Australia* 2:609, 1958. (3) Monro, J. A., & Markham, N. P.: *Lancet* 2:186, 1958. (4) Purser, B. N.: *M. J. Australia* 2:441, 1958. (5) R. E. O., in National Conference on Hospital-Acquired Staphylococcal Disease, Sept. 15-17, 1958, Atlanta, Georgia, U. S. Health, Education, and Welfare, Communicable Disease Center, 1958, p. 11. (6) Rountree, P. M., & Beard, M. A.: *M. J. Australia* 2:441, 1958. (7) Mudd, S.: *J.A.M.A.* 166:1177, 1958. (8) Fischer, H. G.: *Deutsche med. Wochenschr.* 84:257, 1959. (9) Royer, A., in V. & Marti-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 783. (10) Hennessey, R. Miles, R. A.: *Brit. M. J.* 2:893, 1958. (11) Markham, N. P., & Shott, H. C. W.: *New Zealand M. J.* 57:55, 1958. (12) Oswald Shooter, R. A., & Curwen, M. P.: *Brit. M. J.* 2:1305, 1958. (13) Suter, L. S., & Ulrich, E. W.: *Antibiotics & Chemother.* 9: (14) Borchardt, K. A.: *Antibiotics & Chemother.* 8:564, 1958.

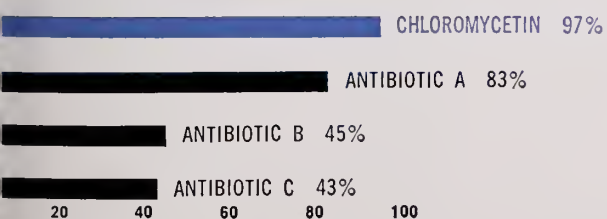


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**BATON ROUGE, LOUISIANA**—Friday, Sept. 18, 1959  
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**BEAUMONT, TEXAS**—Saturday, September 19, 1959  
The Hotel Beaumont

**KANSAS CITY, KANSAS**—Friday, September 25, 1959  
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**INDIANAPOLIS, INDIANA**—Wednesday, Sept. 30, 1959  
The Sheraton-Lincoln Hotel

**OKLAHOMA CITY, OKLAHOMA**—Friday, October 2, 1959  
The Skirvin Hotel

**BIRMINGHAM, ALABAMA**—Sunday, October 11, 1959  
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**TACOMA, WASHINGTON**—Wednesday, October 14, 1959  
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**TRAVERSE CITY, MICHIGAN**—Friday, October 23, 1959  
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**ST. CHARLES, ILLINOIS**—Wednesday, November 4, 1959  
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The Robert Driscoll Hotel

**RIVERSIDE, CALIFORNIA**—Sunday, November 15, 1959  
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**SANTA BARBARA, CALIFORNIA**—Wednesday, Nov. 18, 1959  
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*References:* 1. Sheldon, J. M.: *Postgrad. Med.* **11**:165 (Dec.) 1953. 2. Hubbard, T. F. and Berger, A. J.: *Annals Allergy* p. 350 (May-June) 1950. 3. Kline, B. S.: *J. Allergy* **19**:19 (Jan.) 1948. 4. Goodman, L. S. and Gilman, A.: *Pharmacol. Basis Ther.*, Macmillan, New York, 1956, p. 532. 5. Fabricant, N. D.: *E.E.N.T. Monthly* **37**:460 (July) 1958. 6. Lhotka, F. M.: *Illinois M.J.* **112**:259 (Dec.) 1957. 7. Farmer, D. F.: *Clin. Med.* **5**:1183 (Sept.) 1958.

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# PROGRAM OF THE SYMPOSIUM ON THE PREVENTION AND TREATMENT OF ATHLETIC INJURIES

At the University of Rhode Island, Kingston, Rhode Island  
August 17-18, 1959

## MONDAY, AUGUST 17

### *Morning Session*

#### Moderator

CARL V. SLADER, Associate Professor  
of Physical Education

- 8:00 *Registration*  
Lobby of Keaney Gymnasium
- 8:45 *Welcome*  
DEAN HAROLD W. BROWNING
- 9:00 *Frequency and Nature of Athletic Injuries*  
THOMAS B. QUIGLEY, M.D., Assistant Clinical Professor of Surgery, Harvard Medical School, and Surgeon, University Health Services, Harvard University
- 9:40 *Panel: Abdominal, Genitourinary and Thoracic Injuries*  
LESTER VARGAS, M.D., AND J. ROBERT BOWEN, M.D., Department of Surgery, Rhode Island Hospital  
ANTHONY ROTELLI, M.D., Department of Urology, Rhode Island Hospital
- 10:40 *Insurance Coverage for Athletic Programs*  
School and College Athletic Insurance  
NEAL R. DOWE, Manager of College, School and Camp Department, J. C. Paige and Company, Boston, Massachusetts  
Rhode Island Round Robin  
WILLIAM KUTNESKI, Secretary-Treasurer, Rhode Island Interscholastic Injury Fund and Coach of Football, Providence-Central High School
- 11:30 *Injuries of the Head, Spine and Pelvis*  
JULIUS STOLL, M.D., Chief, Department of Neurosurgery, Rhode Island Hospital  
A. A. SAVASTANO, M.D., General Chairman, Consulting Orthopedic Surgeon
- 12:30 *Luncheon*

### *Afternoon Session*

#### Moderator

S. J. P. TURCO, M.D., Director  
of Student Health

- 2:00 *Injuries of the Foot, Ankle and Leg*  
THOMAS B. QUIGLEY, M.D. AND  
EDWARD COUGHLIN, JR., M.D., Consulting Orthopedic Surgeon, Williams College
- 3:00 *Injuries of the Knee and Thigh*  
G. EDWARD CRANE, M.D., Orthopedic Surgeon, Department of Athletics, Brown University, and  
THOMAS B. QUIGLEY, M.D.
- 4:00 *Principles of Athletic Taping and Wrapping*  
JOSEPH P. DOLAN, PH.D., Research Professor of Health and Physical Education, N. E. Missouri State Teachers College

ERNEST BIGGS, Assistant Professor and Chief Trainer, Ohio State University  
RICHARD K. COLE, Trainer and Assistant Professor of Physical Education

- 6:30 *Chicken Barbecue*  
PRESIDENT FRANCIS H. HORN, *Speaker*

## TUESDAY, AUGUST 18

### *Morning Session*

#### Moderator

PAUL F. CIEURZO, JR., Assistant Director of Athletics and Professor of Physical Education

- 8:30 *Field Examinations and Treatment*  
G. EDWARD CRANE, M.D.  
PROFESSOR ERNEST BIGGS
- 9:15 *Psychosomatic Medicine in Athletics*  
JOSEPH DOLAN, PH.D.
- 9:45 *Injuries of the Upper Extremities*  
A. A. SAVASTANO, M.D.  
EDWARD COUGHLIN, JR., M.D.
- 10:30 *Physical Bases for the Restriction of Participation in Sports*  
WILLIAM J. H. FISCHER, JR., M.D., Department of Medicine, Rhode Island Hospital and  
A. A. SAVASTANO, M.D.
- 11:30 *Panel: Conditioning the Player*  
*Moderator:* PROFESSOR ERNEST A. CALVERLEY, Head Basketball Coach and Assistant Professor of Physical Education  
Football—PROFESSOR ERNEST BIGGS  
Track—FREDERIC D. TOOTELL, Director of Athletics and Professor of Physical Education  
Hockey—THOMAS ECCLESTON, Coach of Hockey, Providence College  
Basketball—FRANK W. KEANEY, Director Emeritus of Athletics and Former Head Coach of Football, Basketball and Baseball

- 12:30 *Luncheon*

### *Afternoon Session*

#### Moderator

HERBERT H. MAACK, Head Football Coach and Associate Professor of Physical Education

- 2:00 *Physical Medicine in the Treatment of Athletic Injuries*  
GEORGE G. DEEVER, M.D., Physician in Charge of Physical Medicine, Bellevue Hospital, New York City and Professor, Clinical Rehabilitation and Physical Medicine, New York University
- 3:15 *Protective Equipment (Demonstration)*  
JOSEPH DOLAN, PH.D.  
PROFESSOR ERNEST BIGGS
- 4:30 *Diets and Prophylactic Inoculations*  
S. J. P. TURCO, M.D., Director of Student Health

*concluded on page 422*

## TELEPHONE MESSAGE

date 6/28 time 8:45  
 from Mrs. Olson  
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aches all over - had  
sore throat  
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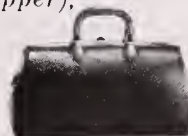
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concluded from page 420

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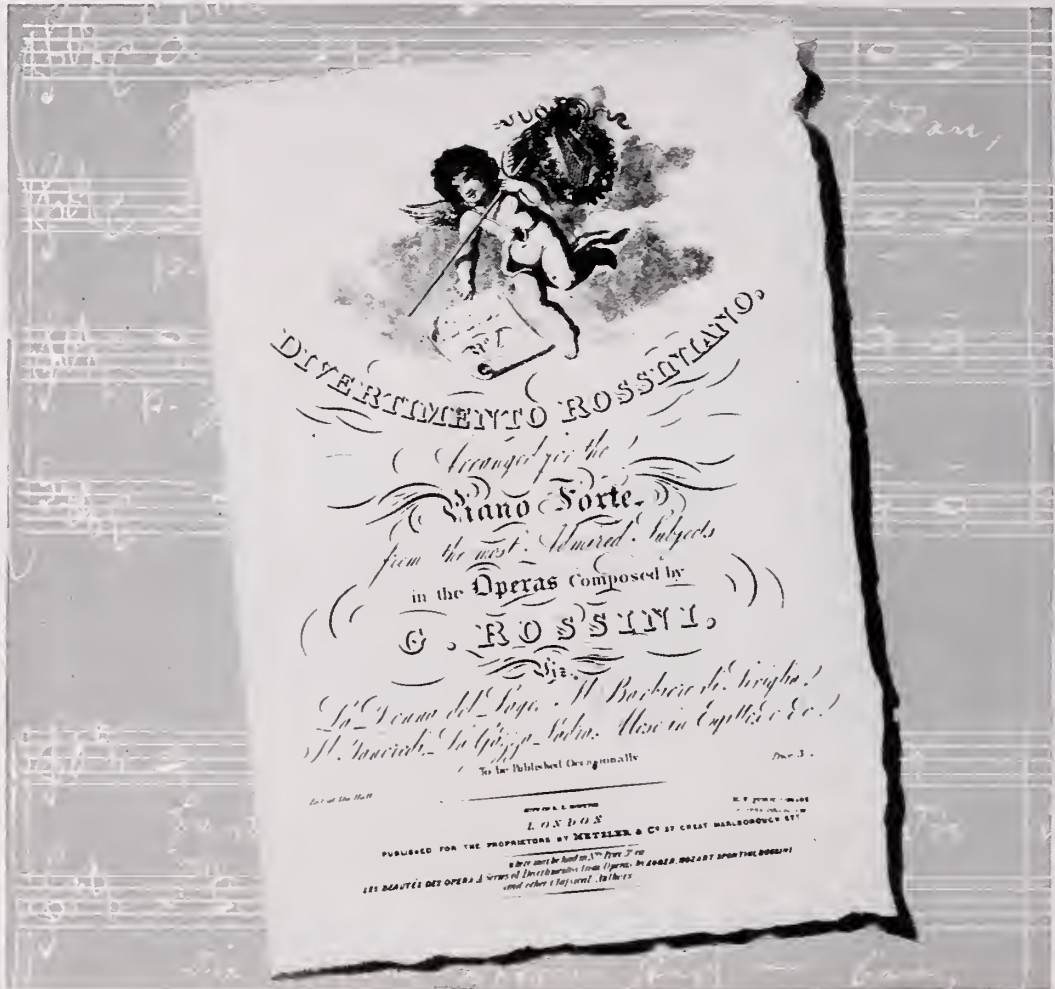
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\*1. Borrus, J. C.: J.A.M.A. 157:157, April 30, 1955. 2. Sellin, S.: J.A.M.A. 157:1594, April 30, 1955. 3. Lemere, F.: Southwest Med. 193:1, Oct. 1958. 4. Benda, B. and Locutti, C.: Lav. neuro-psychiat. 18:693, 1955. 5. Sellin, S.: J. Clin. Exper. Psych. 17:7, March 1956. 6. Berglund, M., Blumenthal, B., and Mordh, P.: Svenska läk. 53:3562, Dec. 1956. 7. Sel, H. A., Wood, J. A., and Dixon, H. H.: New York Acad. Sc. 67:730, May 9, 1957. 8. Hollister, C., Elkins, H., Hiler, E. G. and St. Pierre, J.: Ann. New York Acad. Sc. 67:739, May 9, 1957. 9. G. M.: Rass. med. 34:233, July-Aug. 1957. 10. Li, R. et al.: J. Pediat. Praxis 20:27, Aug. 1957. 11. Wiklund, P.: Anaes-thesist 197, Aug. 1957. 12. Tucker, W. I.: South. J. 50:1111, Sept. 1957. 13. Rolandi, A.: Attual. ostet. 3(6), 9, Nov.-Dec. 1957. 14. Backer, W.: Klin. Mon. 1. August 1958. 15. G. M.: 26(2):143, 1958. 16. G. M.: Minerva 19:1914, 1958. 17. G. M.: 3(1):36, 1958. 18. G. M.: Gazz. med. ital. 114:49, Feb. 1958. 19. G. M.: J. Indian M. Prof. 113, Feb. 1958. 20. G. M.: Therap. 97:66, Feb. 1958. 21. G. M.: Lyon méd. 197, March 2, 1958. 22. G. M.: 10:213, May 1958. 23. G. M.: 25, Sprauer, V. J.: Internat. Rec. Med. GP Clinics 171:1, 1958. 24. McClellan, R.: 1958. 25. G. M.: Robinson, H. M.: 1958. 26. G. M.: 58:1233, April 15, 1958. 27. G. M.: 116, 1958. 28. G. M.: 29. Rebeul, E., Rebeul, M. and Dorgeuille, C.: Maroc 17:784, July 1958. 29. G. M.: 200:885, Nov. 1958. 30. G. M.: 53:2113, Dec. 1958. 31. Lamphier, T. A.: Maryland M. 7:627, Nov. 1958. 32. G. M.: 53:2113, Dec. 1958.

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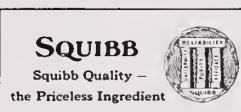
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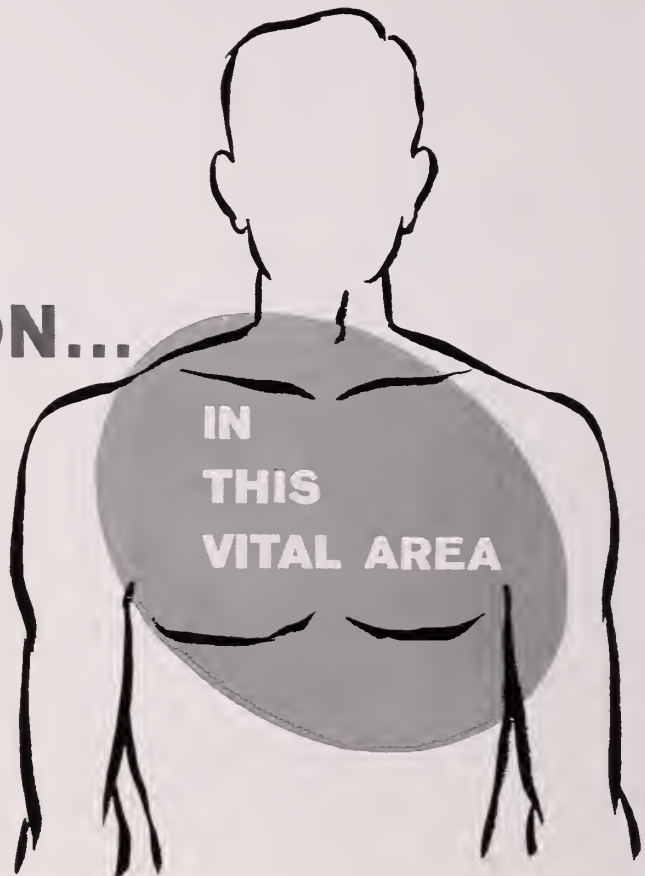


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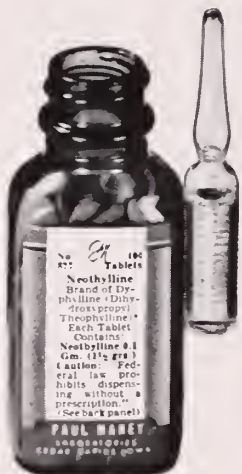
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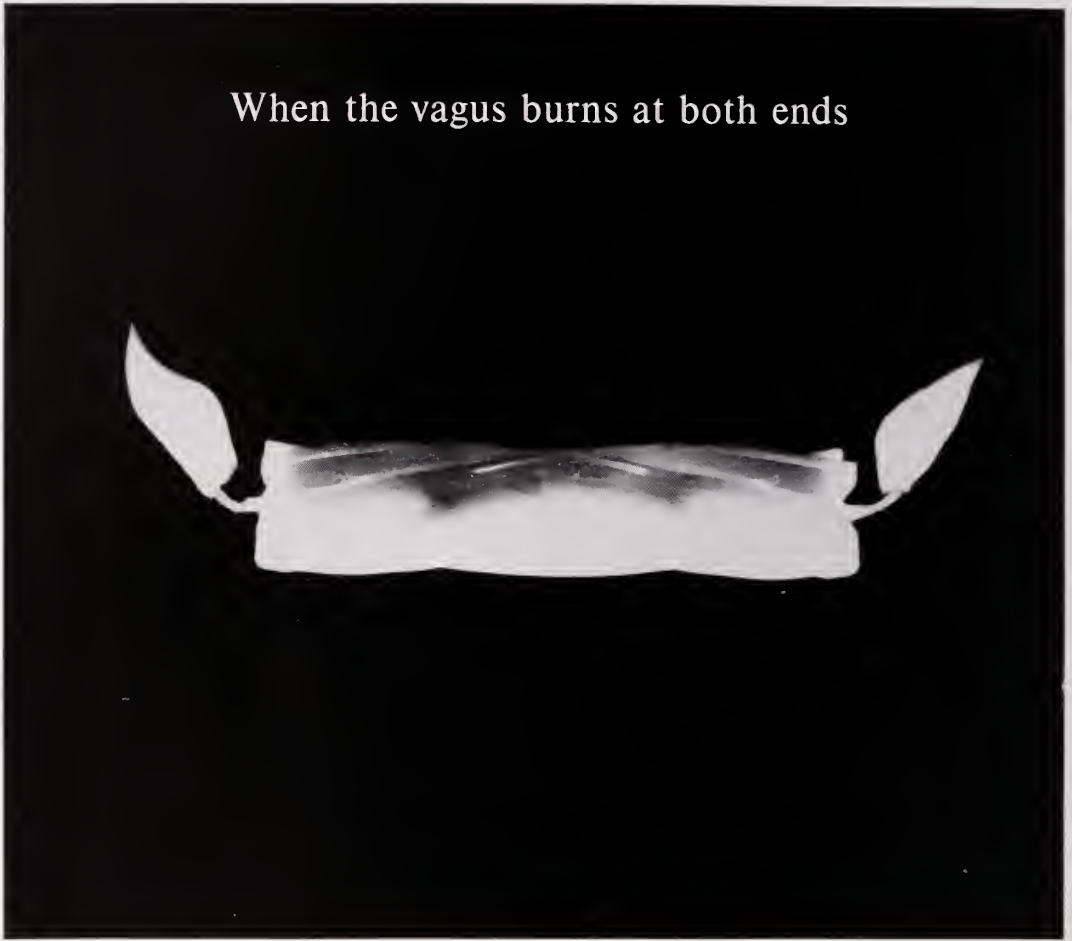
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## SURVIVAL MEDICINE IN THE SOVIET UNION

LEONID S. SNEGIREFF, M.D.

The Author, *Leonid S. Snegireff, M.D., of Boston, Massachusetts. Associate Professor of Cancer Control, Harvard School of Public Health; co-author of "The Report of the U.S. Public Health Mission to the U.S.S.R." (August 13-September 14, 1957. U.S. Departments of Health, Education, and Welfare, 1959. U.S. Government Printing Office)*

THE RUSSIAN STATE and the Russian people are so organized that they can go from peace to war and war to peace with very little shift in their medical economy. This situation is a distinctly planned one for the purpose of survival. Homes may be destroyed, people moved from place to place in thousands and industries wiped out, but the disruption would be less paralyzing than would be true in this country under similar circumstances.

Medical services are reasonably plentiful, although they are not the kind of private and voluntary medical services as we understand them in the U.S.A. It is true, however, that the basic underlying support for the people from the standpoint of morale, from the standpoint of need is a well-integrated medical service of sorts.

All members of the medical services are basically capable and would think nothing of it if they were obliged, under certain circumstances, to drop the medical services in which they were participating and fill in in industry or in agriculture for a required period. This epitomizes the type of organization present in the U.S.S.R.

There are at least three distinct classes of physicians: the sub-professional category of feldschers, the rank and file graduate with a physician's diploma, and the graduate with a degree in Medical Sciences. There are eighty-seven medical teaching institutes training physicians and 400 so-called "medical schools" producing sub-professional physicians who are called feldschers—whom we might term corpsmen. The upper third of the graduates of the eighty-seven medical institutes are well trained and have good prospects for distinguished careers in medicine. Certain ones are selected for research

and these pass into the highest class of physicians equivalent to our doctors of medicine; they are members of teaching staffs in the medical teaching institutes and in the research institutes. Medical education is free, but all physicians must serve three years wherever the State wishes to send them immediately after graduation. After this assignment has been completed, they may apply for another location and if there are openings, they might be transferred. Physicians may have a number of the sub-professional feldschers or corpsmen helping them in the remote rural areas which they must cover. The corpsmen or sub-professional type of practitioners are practically versed in public health, occupational medicine, midwifery, and first aid. They may be working alongside the farmer on his collective farm at a first-aid station or doing their medical job in a rural hospital. They are, where practicable, responsible to the physicians for more detailed medical work. They are also in a position of having to serve for three years or longer in places designated by the government and only then can application be made for a position of their choice or for continued study of medicine in a medical teaching institute. Postgraduate courses are usually relatively short and rarely exceed three or four months.

There seems to be a developing public health consciousness among the people even in the rural areas. Occupational health is also becoming quite a factor and is practiced universally. A particular type of comprehensive medical care is that rendered by the railroad medical service which is a transportation organization and is to be found throughout the length of the railroads. This is a special service financed by the Railroad Transport Bureau, while other physicians and public health specialists receive their salaries from the Ministry of Health. Physicians of the Railroad Transport Service are nevertheless professionally responsible to the Ministry of Health, and technically come under the administrative supervision of the area health officer.

A total of 60-80% of physicians are women; they form a majority of the cadre of both professional workers and the sub-professional corpsmen type of

*concluded on next page*



medical workers. The system of training sub-professional personnel is very elastic; the state changes curricula and the technical training of personnel according to the felt needs of the country. Thus, at present, nurses exceed Table of Organization needs so that other ancillary medical personnel are given training priority.

There is an Academy of Medical Sciences composed of some 220 members—mostly male. These are the elite of the medical world in the Soviet Union. They live better, receive a higher salary, and spend their time in research and teaching. Election to membership in the Academy provides a salary of \$175 or 1750 rubles a month for life for "Corresponding Members" and \$350 or 3,500 rubles a month for full or actual "Members."

There are public health specialists in the top level as well as in the lower levels. Top level administrators are Members of the Ministry of Health of the U.S.S.R. and of the individual states or republics which form the Union. Special public health units are assigned to certain regional hospitals; similar counterparts to these regional hospitals are found in rural areas.

#### *Extent of Medical Knowledge*

As far as the number of persons per physician is concerned, the Soviet Union, though woefully lacking in numbers of well-trained physicians who would measure up to our medical standards, makes up for this numerical disadvantage when the feldschers, *i.e.*, sub-professional corpsmen, are added to the professional group of physicians; in general there is a fair representation of medical knowledge in the population. Sub-professional persons occasionally may act in emergencies to perform surgical operations or take such special medical action as is indicated. They must, however, clear with the nearest collaborating physician, or in his absence, with a competent political administrator on the spot, if possible, before anything is done so that there is administrative sanction of the action. The feldscher or corpsman type of physician is thus used to extend the knowledge and skill of the physician, particularly in the rural areas.

The economy, medical planning and training of all classes of the Soviet people and of physicians are on the long-range survival level.

They are well indoctrinated and from an organizational standpoint are able to go from peace to war and war to peace with relatively little change. The parent group in charge in the Soviet Union has had forty years of experience in survival training. They practice survival training in earnest all the time; for example, right after the Youth festival in 1957, classes in medical teaching institutes were postponed for one month, because all students, excepting the seniors who had clinical obligations to the local population, were allowed to volunteer "to bring in

the harvest."

The present program of training physicians in a public health climate of survival medicine dates back thirty years, when in 1929 medical training was taken out of the universities; the faculties of medicine were thus disbanded and the degree of Doctor of Medicine was abolished. The quantity of medical workers needed was emphasized at the expense of quality of the average medical practitioner trained. Political indoctrination became an essential part of the new curriculum in the medical training programs approved by the Communist party for medical teaching institutes. Comprehensive state medical examinations were abolished to a point where only two are now given: One at the end of the second preclinical year, and this examination is confined to the subject of chemistry and is designed to test the student's knowledge of a basic science and the outcome of this examination determines the ability of the student to go on to clinical studies. Throughout the six years of pre-medical and medical studies, every student must attend the prescribed weekly lectures on political economy, history of the Communist party and history of revolutions. The second occurs at the end of the sixth year and is designed to test the perspective graduate's knowledge in political matters; this examination must be passed before each physician's first professional assignment is made by the Ministry of Health. Soviet leaders have managed to foster a thorough suspicion of the intellectual classes and have brought about political indoctrination of the new generation of Soviet physicians. This indoctrination pushes the rank and file physician to keep up his maximum production of services—which includes his own record keeping, issuance of many certificates and filing—without giving thought to medical research. Only the elite with degrees of Candidate of Medical Sciences or of Doctor of Medical Sciences can give any continuing thought to research, and they are in the research institute and in the laboratories of medical teaching institutes.

In Soviet society the citizen owns very few material goods and is not really "land-tied," hence he is highly mobile at a moment's notice ready to travel where his government orders him to go; thus disciplined, having little choice but to obey. Transition of peace to war is for him of a much less severe impact than such transition would be for our citizens who, unlike the Soviet people, own far more than that which they wear on their backs.

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#### **Interim Meeting . . .**

**September 23, 1959**

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## TREATMENT OF THROMBO-EMBOLIC DISEASE BY LIGATION OF THE INFERIOR VENA CAVA\*

JOHN B. BLALOCK, M.D., KENNETH MEYER, M.D.,  
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COAGULATION OF BLOOD in the venous system is an enigma that occurs in such a variety of patients that scarcely any medical specialist is exempt from caring for such patients from time to time. In spite of extensive clinical and experimental investigations of this problem, the etiology continues to be shrouded in mystery, and there is much confusion as to the optimum method of treatment. The condition gains importance because of the deleterious effect on the function of the segment of the venous system involved and because of the actual or potential association of pulmonary embolism.

The local sequelae of such a process may range from none at all to all degrees of impairment of function of the venous and lymphatic systems including the condition known as "the postphlebotic syndrome." Although such complications are virtually never fatal in themselves, they can result in chronic crippling disabilities. On the other hand, occurrence of pulmonary embolism invariably heralds a potentially fatal outcome, if indeed, the initial episode is survived.

A wide variety of regimens has been employed through the years in an effort to attain a reliable method of preventing intravenous thrombosis. To date there is no convincing evidence that any of the numerous measures directed toward prophylaxis is effective, and in spite of our best efforts, we continue to be confronted with patients who require treatment of this ailment. There are few conditions in medicine for which such widely divergent methods of treatment have been advocated. Recommended therapy ranges from none at all to vigorous medical or surgical measures. Although each case must be evaluated individually, in general we physicians cannot vacillate between the widely di-

vergent modes of treatment and are forced to adopt our preferred method of treatment.

The decision as to the method to be employed should take into consideration the eventual effect that it will have on the patient as well as the efficiency with which it will handle the immediate problem. The points with reference to treatment that deserve most consideration are the influence, be it favorable or unfavorable, that the treatment may have on the local problem of the phlebotic syndrome and the success with which it will prevent pulmonary embolism.

The school of thought that advocates "conservative" therapeutic measures, which consist, in effect, of employing no specific therapy other than possibly rest and elevation of the extremities, is a passive one that depends on recanalization and development of venous collateral circulation to lessen the local effect. The problem of embolization seems to receive little consideration unless it is that the reduced physical activity would reduce the chance of its occurrence.

The second possible method of therapy, which we have chosen to call medical, although it is probably more frequently supervised by surgeons than by internists, is utilization of measures designed to lessen the coagulability of the blood by use of coumarin-like or heparin-like preparations for the most part.<sup>1-3</sup> When employed after intravenous thrombosis has occurred, there is little evidence that these agents cause dissolution of the thrombi although they do prevent or minimize the further propagation of the thrombi if they are employed in sufficient dosage. There is considerable variation in the individual susceptibility to the medication employed and there seems to be a strong tendency to attribute therapeutic failures to improper utilization of the method. There is good reason to believe that this method of therapy should have a beneficial effect on the thrombotic sequelae,<sup>1</sup> but its efficiency in control of pulmonary embolism leaves much to chance. At this point, the concept that intravenous lysis of thrombi can be done without production of embolization should be mentioned. Encouraging investigation is now in progress which offers hope that a safe thrombolytic agent may soon be developed.<sup>4</sup>

\*Presented at the 148th Annual Meeting of the Rhode Island Medical Society, Providence, Rhode Island, May 13, 1959, by John B. Blalock, M.D.



The third concept in treatment is that venous ligation is the most direct solution of the problem of pulmonary embolization.<sup>5-9</sup> However, it must be emphasized that few believe that it is of therapeutic benefit in the postphlebotic syndrome. There seems to be little argument that if a ligature is applied around the venous system between the level of thrombotic disease and the heart, no further embolization will occur from this area. Room for argument does exist as to when one can be certain that he has ligated proximal to the source of trouble and whether one has assurance that further thrombosis will not occur proximal to the level of ligation. Numerous, well-documented cases of further embolization after ligation at the femoral level have been reported,<sup>10,11</sup> and indeed, cases of further embolization after ligation of the inferior vena cava are on record.<sup>7</sup> Such an occurrence is attributed to development of further thrombosis in the lower end of the vena cava, and we have no assurance that such does not occur. Another possible explanation would be an error in the supposed ligation of the vena cava. Such an error would seem to be inexcusable but we have had two cases in which the right common iliac vein was isolated and once actually temporarily ligated on the assumption that it was the inferior vena cava. Failure to recognize such an occurrence would offer a most logical explanation for the rare embolus that is reported to occur after ligation of the inferior vena cava.

In the light of present knowledge it seems highly unlikely that ligation proximal to the level of thrombotic disease could beneficially affect the local process, as was advocated by some a decade ago, and the decision as to its employment must be appraised on the basis of whether or not it has a deleterious effect and if so the magnitude of this effect. Advocates of ligation early learned that optimum venous collateral circulation from the lower extremity was possible if the level selected for ligation was either at the superficial femoral or at the inferior vena cava.<sup>12,13</sup> Ligation between these levels was attended by troublesome sequelae in a significant percentage of patients. Whether or not they were superimposed on thrombotic disease, such sequelae seemed largely a manifestation of impaired venous collateral circulation. Preservation of the profunda femoris vein at the groin and of free communication between the right and left venous systems of the pelvis appears to be of utmost importance in establishing venous collateral circulation. Association of impaired lymphatic return from the lower extremities in the postphlebotic syndrome has long been recognized as a most important one, and it has been impossible to separate completely the components of the general disability which is on a venous and on a lymphatic basis.<sup>6</sup>

TABLE I  
Annual Distribution of 117 Cases  
of Inferior Vena Cava Ligation

Year	Cases
1945	1
1946	0
1947	1
1948	4
1949	9
1950	11
1951	13
1952	12
1953	11
1954	12
1955	13
1956	8
1957	7
1958	15

After consideration of the various avenues of therapy open to the physician attending a patient with thrombo-embolic disease, his choice must be made on the basis of what is best for the individual patient. The preferred method of treatment of such patients in the Department of Surgery at the Ochsner Clinic during the past fourteen years has been venous interruption at a level presumably above the venous thrombosis. During this time ligation of the inferior vena cava was performed in 117 cases. To the best of our knowledge, none of these patients has experienced a subsequent pulmonary embolus, and no deaths could be attributed to the operation.

As can be seen from Table I, about the same number of cases were performed each year during the past decade. The predisposing causes of thrombo-embolic disease in these 117 patients are listed in Table II and the most frequent signs and symptoms in 114 cases of proved thrombo-embolic disease are shown in Table III. Of the 117 patients, 88 were operated upon by the extraperitoneal approach and 29 by the transabdominal approach. The major indications for operation are shown in Table IV. The first diagnostic error was in a young woman who had clinical and radiologic evidence consistent with a diagnosis of massive pulmonary embolization, and, at necropsy was found to have

TABLE II  
Predisposing Causes of Thrombo-embolic Disease  
in 117 Patients

Cause	Cases
Medical illness	14
Postoperative	55
Postpartum or post-abortion	7
Post-trauma	6
No apparent cause	15
Post-effort	2
Flare-up of postphlebotic disease	18



bilateral confluent bronchial pneumonia and pericarditis. The operation apparently did not contribute to the fatal outcome in this case. The second diagnostic error occurred in a lady whose electrocardiogram was recorded as pathognomonic of a massive pulmonary embolus, but which subsequently proved to be due to myocardial infarction. Fortunately, the patient made an uneventful recovery. The one case of prophylactic ligation was performed at the conclusion of radical pelvic extirpation for carcinoma.

Ninety-one patients have been followed from six months to thirteen years postoperatively (Table V). Two of the 117 patients could not be traced. None of the twenty-four deaths in the series was attributed to the operation, further embolization or consequences of the postphlebotic syndrome. In Table VI the sequelae are compared on the basis of the duration of thrombo-embolic disease at the time of ligation in the 91 patients followed six months to thirteen years.

These operations were performed for thrombo-embolic disease in patients who had already experienced a pulmonary embolus or in whom the likelihood of embolization seemed eminent enough to indicate ligation as maximum protection against embolization. Among these patients there were fourteen who had had bilateral ligation of the superficial femoral vein and who had subsequently experienced pulmonary embolization.

It should be emphasized that all these patients were candidates for the postphlebotic syndrome whether or not vena cava ligation was performed. The components of the postphlebotic syndrome, such as pain, secondary varices, recurrent erysipelas infection in the skin and subcutaneous tissues and ulceration seem to be in direct proportion to the amount of edema formed.<sup>6</sup> We are convinced that in this series of private patients the conscientious care of their extremities has been the greatest factor in keeping the severity of sequelae to an acceptable level. During the postoperative period they are instructed in the use of compression bandages and periodic elevation of the extremities. They soon learn that suppression of edema by application of compression on first arising is far more effective than to try to "milk out" the edema after it has been allowed to form. The benefit of following and the penalty of not following the regimen are immediately evident and the intelligent patient becomes imbued with the urgency of keeping the extremities as free of edema as possible. Some patients never have edema. The majority do have a mild to moderate degree for the first few months and a few require use of compression bandages or stockings for a period of several years. The most important single deterrent to satisfactory control of edema, and thereby the additional sequelae, is obesity. It is

TABLE III  
Clinical Manifestations in 114 Proved Cases  
of Thrombo-embolic Disease

Clinical Manifestation	Cases
Extremity edema .....	59
Positive Homans' sign .....	45
Pulmonary embolus and thrombotic process .....	42
Thrombotic process only .....	38
Hemoptysis .....	34
Pulmonary embolus only .....	21

TABLE IV  
Indication for Ligation of  
Inferior Vena Cava in 117 Cases

Major Indication	Cases
Pulmonary infarct .....	72
Phlebothrombosis .....	19
Non-septic thrombophlebitis .....	12
Septic thrombophlebitis .....	11
Diagnostic error .....	2
Prophylactic .....	1

TABLE V  
Results in 91 Patients Observed  
from 6 Months to 13 Years  
After Ligation of Inferior Vena Cava

Follow-up	Cases
No sequelae .....	45
Mild edema—no disability .....	13
Edema controlled by bandages .....	28
Edema controlled by bandages and periodic elevation .....	5
Incapacitating sequelae .....	0
<i>Total</i> .....	91

TABLE VI  
Comparison of Sequelae on Basis of Duration  
of Thrombo-embolic Disease at Time of Ligation  
in 91 Cases Followed 6 Months to 13 Years

Sequelae	One Month or Less	More than One Month
None .....	35	10
Mild edema—no disability .....	5	8
Edema controlled by bandages .....	12	16
Edema requiring bandages and periodic elevation .....	2	3
Incapacitating sequelae .....	0	0
<i>Total</i> .....	54	37

virtually impossible to apply effective compression bandages to flabby, fat extremities. Perseverance in controlling edema and any tendency toward obesity is rewarded in almost every instance by progressive lessening of the sequelae with the passage of time, and the postphlebotic syndrome can be kept to an acceptable degree as compared with victims of this syndrome who have not had ligation of the inferior vena cava. This impression, coupled with the almost certain assurance of obviation of further embolism, has encouraged us to continue employment of this method in selected patients whose lives are threatened by actual or potential pulmonary embolism.

## THE OBSTRUCTED EAR\*

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THE EAR POSSESSES two primary functions: First, the reception and transmission of sound through the hearing apparatus, and secondly, it contains the vestibular or balance apparatus. It is with the first that we are primarily concerned in this presentation. Exactly how we hear is a problem for physiologists and neuro-anatomists, but suffice it to say that sound is received into the external auditory canal, sets the tympanic membrane and ossicular chain into motion and transmits these vibrations through the oval window to the fluids of the internal ear, and thence to the hair cells of the acoustic nerve. Any obstruction to this passage of sound waves from the outside world to the inner ear gives the symptoms and signs which are being grouped here under the inclusive term of *The Obstructed Ear*. The result is some degree of impairment of hearing.

Figure I shows the main causes of this disorder. It may be constant in a patient whose hearing is impaired by otosclerosis, or present only at certain times, as in the child or adult with a large adenoid mass that obstructs the Eustachian tube opening when the edema of an acute respiratory infection is present. It may vary with the position of the head, as in an ear canal nearly filled with a foreign body, debris from an external otitis, or a large mass of cerumen, where compression on a pillow may completely block the canal, or in a middle ear where the fluid of an acute or chronic catarrhal process gives a muffled effect to the hearing when the head is tilted backward and the fluid is against the oval and/or round windows of the hearing apparatus.

### History

For many years the only treatment for hearing loss was an ear trumpet and later the electric hearing aid. To be sure, many reports reached the literature of various surgical procedures which were devised

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### CAUSES OF OBSTRUCTED EAR SYNDROME

#### EXTERNAL OTITIS

#### CONGENITAL ATRESIA OF EXTERNAL CANAL

#### OSTEOMATA OF EXTERNAL AUDITORY CANAL

#### POLYPI OF EXTERNAL AUDITORY CANAL

#### FOREIGN BODIES OF THE EXTERNAL AUDITORY CANAL

#### ACUTE CATARRHAL OTITIS MEDIA

#### CHRONIC CATARRHAL OTITIS MEDIA

#### ACUTE PURULENT OTITIS MEDIA

#### CHRONIC PURULENT OTITIS MEDIA

#### HYPERTROPHIED TONSILS AND ADENOIDS

#### CHRONIC EUSTACHIAN OBSTRUCTION

#### ALLERGIC RHINITIS

#### TUMORS OF THE NASOPHARYNX

##### A. BENIGN

##### B. MALIGNANT

#### PERFORATIONS OF THE MEMBRANA TYMPANI

#### DISEASES OF THE OSSICLES

#### OTOSCLEROSIS

### FIGURE I

by pioneers in this field, but were discarded because of two things—the threat of infection, and the technical difficulty of visualizing and working on the structures involved. The first obstacle was largely eliminated with the advent of the two-edged sword, antibiotics. The second was changed with the advent of new types of electrical headlamps and the use of magnifying glasses, loupes, and microscopes. Lempert,<sup>1</sup> in 1938, gave the otological world its impetus to progress with the announcement of his fenestration operation for the surgical treatment of the particular type of obstructive hearing loss due to the disease called otosclerosis. This started ear surgeons working on cases of deafness and subsequent developments have been such that surgery and increasing knowledge of all types of deafness have arisen in the span of a few years. In 1946,

Lempert<sup>2</sup> devised the operative technique of working on the middle ear by laying part of the eardrum and skin lining of the external auditory canal forward like an apron and then placing it back at the end of the surgery. This procedure for mobilizing the stapes was then developed by Rosen, Scheer, House, and others. It has now become commonplace and with it has come a large increase of knowledge about the hearing apparatus.

Although this is a very dramatic surgical procedure, the cases of impaired hearing due to otosclerosis make up a relatively small part of the total. The largest percentage are those with obstructions due to Eustachian tube disorders and catarrhal disorders of the middle ear. In a previous paper, presented in collaboration with Doctor Francis Sargent, in November, 1957,<sup>3</sup> the writer discussed the diagnosis and treatment of these cases, and their relationship to allergy was stressed. Weeks,<sup>4</sup> in 1958, quoted the incidence of allergy in about seventy-five per cent of cases of secretory otitis media, and reported eighty-four per cent to ninety-three per cent improvement with antihistamine therapy. This percentage has not been reached in our hands, but the control of any existing allergy is necessary in all of these cases.

Within the past decade several facts regarding hearing loss of the conductive type have emerged. The most important of these is that many, if not most, cases can be prevented or relieved by treatment—either by surgery or radiation. In other words, many of the cases have had fluid left in the middle ears from previous infections and the removal of the tonsils and adenoids has failed to give the expected improvement. This fluid has apparently remained following ear and nasal infections, especially in the cases of earaches treated only by antibiotics and sedation.

In adults, the treatment of the complications by surgery in the form of myringoplasty and tympanoplasty is a rapidly growing field and extremely rewarding. However, our main concern is with the prevention and treatment of these cases during childhood, while the process is still reversible.

# Incidence

Figure II shows a normal audiogram with hearing at the zero level, in both ears in all frequencies. Variations up to the plus ten decibel line or down to the minus ten decibel line are considered to be normal hearing. If hearing is below the thirty decibel level within the speech frequencies, there is serious impairment for ordinary conversation.

The school hearing testing programs provide for a notice home where a child has two or more frequencies below the thirty decibel level.

In Pawtucket, Rhode Island, with a school population last year of 15,204; 8,002 were tested and 304, or 3.6 per cent of the children were found with this severe amount of hearing loss.

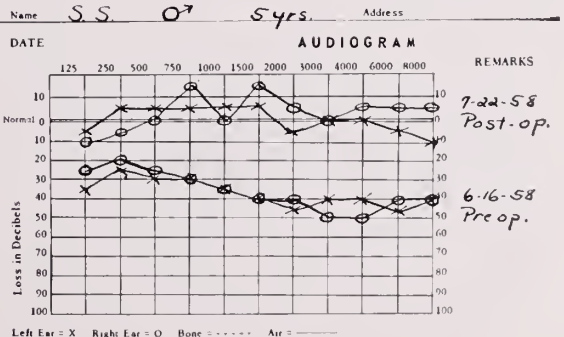
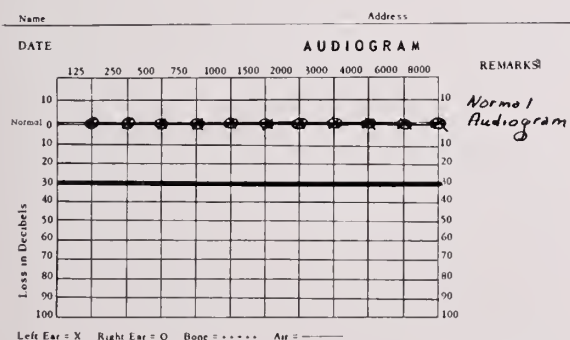
In Providence, with a school population of 29,000; 394 or 4 per cent minus were found; however, only about 10,000 are tested each year. In the Providence parochial schools, 1,877 children of 14,159 were tested, and 115 with hearing loss, or 6 per cent were found.

In Warwick, of 8,113 children tested, 204, or 2.4 per cent were found. This amount of hearing loss will produce difficulty with ordinary conversation. From these figures we can only estimate the number of children with a ten to twenty-five decibel loss that is reversible at the present time, but if untreated, will result later in some degree of deafness. It is estimated that five per cent of the school children in the United States have a hearing loss that requires medical or educational attention, or both, but when the group with these less severe, but reversible losses is included, the figure is greatly increased.

Schoel,<sup>5</sup> in Norway, in 1956, examined 151 children who had recovered from an acute otitis media and found twenty-five per cent with impaired hearing. If the infection had lasted under two weeks, less than five per cent had residual difficulties, and when a myringotomy had been performed, there was impairment only half as often as when the ear was allowed to rupture spontaneously.

What then has happened? Jordan,<sup>6</sup> in 1955, wrote that he felt that in recent years there had

*continued on next page*



FIGURES II and III



been a change in the flora of the nasopharynx in children. He felt that antibiotic therapy has not controlled recurrent ear infection and recommended allergic control and the use of autogenous vaccines in addition to surgery. Davison,<sup>7</sup> on the other hand, feels that under-treatment of infections is the answer, and advocates using three million units of fortified procaine penicillin daily by injection for children under six years of age with an acute ear infection, five million units per day for children over six years, up to ten million units per day for adults, continuing treatment for five to eight days. Glycerine ear drops were shown to be of little value and early myringotomy was stressed.

Armstrong,<sup>8</sup> in 1956, had advocated leaving a tiny plastic tube through an opening in the tympanic membrane for drainage of the middle ear, but few converts to this treatment have been found.

Baron,<sup>9</sup> in 1957, stated, "The most effective treatment of nasopharyngeal lymphoid tissue is meticulous surgery which has no therapeutic equal." He is critical of the operative technique of some of his fellow otolaryngologists and now does a bilateral myringotomy, at the time of the T&A, on any child with a conductive hearing loss, and thus showed further improvement over his own meticulous surgery.

Theobald,<sup>10</sup> in December, 1958, made three important contributions. First, the whisper test shows the parent that their child's hearing is subnormal. Second, the incidence of chronic secretory otitis media in children is increasing because of the frequent and indiscriminate use of antibiotics plus extreme conservatism in recommending adenoidectomy in children. Third, secretory otitis media should be suspected in children who have frequent earaches or hearing losses.

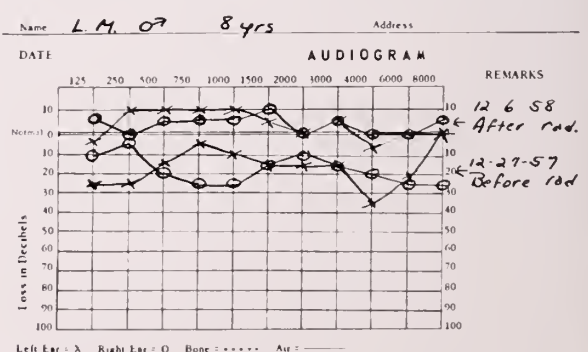
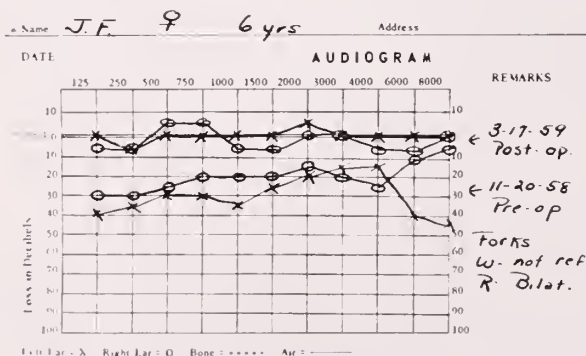
In January, 1958, Welhrs and Proud<sup>11</sup> gave their results following bilateral myringotomies at the time of the T&A in seventy-two children. These were done if signs of conductive type hearing loss were present even though the eardrums often had a normal appearance. All of the children had fluid present and there was uniform improvement in the hearing. Like others, they were prompted to this

study after finding some children previously benefited by T&A surgery and others who were not helped.

All of us in the field of otolaryngology have been impressed by the same facts. There has been a considerable increase in children with obstructive ear symptoms and signs. Subnormal hearing by tuning fork and audiometer testing in the presence of normal-appearing eardrums is disturbing, as the accuracy of the testing, especially in younger children, is the first consideration. The changing pattern of the tests, with poor hearing during or following mild or even moderately severe infections, with normal hearing in the interim is disturbing to the observer. However, the marked improvement following myringotomies and the removal of glue-like secretions from the middle ear in a large number of cases gradually restores one's self-confidence in his diagnostic acumen. In the period from January 1, 1958 to April 28, 1959, the author has performed myringotomies on a series of one hundred five children for this condition. A few were done apart from tonsil and adenoid surgery, but usually at the same time. In ninety-one children both ears were done, in eight children the left ear only, and in six children, the right ear only. No complications have been observed and the results have been uniformly good. Several did not clear completely until intensive antihistamine therapy was added and even then temporary hearing loss during allergy flare-ups may still occur.

Figure III shows the audiogram of a five-year-old boy—S.S., who had his tonsils removed elsewhere a year before being seen, and had multiple earaches treated without drainage during the previous year. At operation, both middle ears were filled with thick, stringy mucoid fluid, which was removed by suction, and you see his post-operative audiogram, with a return of hearing to normal in both ears. Subsequent to this examination, extensive allergy studies have been carried out and multiple plus reactions were found.

Figure IV—J.F., a six-year-old girl, was brought in by the parents because a hearing loss was thought to have come on after a cold. The hearing loss pres-



FIGURES IV and V

ent was relieved after tonsils and adenoids were removed and thick mucous plugs were suctioned from each middle ear, after a myringotomy, giving this final result.

Figure V—L.M., a six-year-old boy on whom a T&A and a right myringotomy was done, as there was still evidence of fluid present. After several episodes of flare-up, three radium treatments were given at monthly intervals. The hearing before and after the radium treatments is shown.

Lemon,<sup>12</sup> in November, 1958, reported his results in a series of one hundred sixteen children, eighty-six of the cases in conjunction with adenoidectomy. Of the two hundred twelve ears opened and suctioned, one hundred seventy-four showed fluid present and thirty-eight were dry. Most important of all was the fact that every child in the series had received antibiotics for earache within the preceding year. This compares very closely with our figures and observations.

### SUMMARY

The obstructed ear causes a relatively frequent symptom-complex which may be present in children or adults and the return of hearing to a normal level can usually be secured. The addition of a bilateral myringotomy with removal of retained glue-like middle-ear secretions by spot suction appears to be capable of restoring the hearing in many children in whom the hearing loss was unsuspected by the family, but the hearing loss or other evidences of the obstructed ear syndrome has been diagnosed by a careful otological examination. The performance of this procedure should prevent many cases of hearing loss in adults at a time when it is not reversible.

The other causes of this syndrome, in children or adults, are usually amenable to treatment, either medical or surgical. Hearing loss due to these causes should be treated to eliminate such disabilities as can be remedied.

### REFERENCES

- <sup>1</sup>Lempert, J.: Improvement in Hearing in Cases of Otosclerosis; New One-Stage Surgical Technic. *Arch. Otolaryng.* 28:42-97, July, 1958
- <sup>2</sup>Lempert, J.: Tympano-Sympathectomy: Surgical Technic for Relief of Tinnitus Aurium. *Arch. Otolaryng.* 43:133-212, March, 1946
- <sup>3</sup>Sargent, F. B., and Gammell, E. B.: Post-Tonsillectomy and Adenoidectomy Deafness in Children Caused by Non-Suppurative Otitis Media. *R. I. Medical Journal*, XLI, No. 4, p. 191, April, 1958
- <sup>4</sup>Weeks, D. J.: Secretory Otitis Media and Nasal Allergy (Preliminary Report of Sixty-six Patients Treated with Promethazine). *Arch. Otolaryng.* 68:6, pp 748-751, December, 1958
- <sup>5</sup>Schoel, T.: Acute Suppurative Otitis Media in Children 0-10 Years of Age: A follow-up examination, especially in regard to hearing. *Acta Oto-Laryng.* 46:422-438, September-October, 1956

- <sup>6</sup>Jordan, R. E.: Nasopharyngeal Lymphoid Tissue and Its Relationship to Hearing. *Arch. Otolaryng.* 62:6, pp 579-582, December, 1955
- <sup>7</sup>Davison, F. W.: Otitis Media Then and Now. *Laryng. LXXV*:3, pp 142-151, March, 1955
- <sup>8</sup>Armstrong, B. W.: A New Treatment for Chronic Secretory Otitis Media; *Arch. Otolaryng.* 59:p. 653, (June, 1954)
- <sup>9</sup>Baron, S. H.: Surgery vs. Irradiation in Therapy of Conduction Deafness of Tubal Origin. *Laryng. LXXVII*: 8, pp 763-776 (August, 1957)
- <sup>10</sup>Theobald, P. W.: Secretory Otitis Media in Children. *Arch. Otolaryng.* 68:6, pp. 737-747 (December, 1958)
- <sup>11</sup>Wehrs, R. E., and Proud, G. O.: Conductive Deafness in Children. *Arch. Otolaryng.* 67:1, pp. 16-19 (January, 1958)
- <sup>12</sup>Lemon, A. N.: Serous Otitis Media in Children. *Arch. Otolaryng.* 68:5, pp 567-573, November, 1958

### TREATMENT OF THROMBO-EMBOLIC DISEASE BY LIGATION OF THE VENA CAVA

*concluded from page 443*

### CONCLUSIONS

Few physicians are exempt from the responsibility of attending patients suffering from thrombo-embolic disease. Inferior vena cava ligation should be utilized in selected patients to afford the maximum protection against pulmonary embolism. With proper postoperative care the local sequelae of thrombo-embolic disease can be made negligible or kept to a degree compatible with that anticipated for victims of the postphlebotic syndrome treated by methods other than ligation.

### REFERENCES

- <sup>1</sup>Zilliaceus, H.: On the specific treatment of thrombosis and pulmonary embolism with anticoagulants. *Acta med. Scandinav. Supp.* 171. Pp. 1-221, 1946.
- <sup>2</sup>Allen, J. G., et al.: The physiology of intravascular coagulation in health and disease. *S. Clin. North America* 37:1473-1506 (Oct.) 1957
- <sup>3</sup>Olwin, J. H.: Treatment of thromboembolism. *J.A.M.A.* 160:1101-1105 (March 31) 1956
- <sup>4</sup>Sokal, J. E.; Ambrus, J. L., and Ambrus, C. M.: Treatment of thrombosis with fibrinolysin (plasmin). *J.A.M.A.* 168:1314-1323 (Nov.) 1958
- <sup>5</sup>Byrne, J. J.: Phlebitis; study of 748 cases at Boston City Hospital. *New England J. Med.* 253:579-586 (Oct. 6) 1955
- <sup>6</sup>Zollinger, R. W., and Teachnor, W. H.: Late results of inferior vena cava ligation for thromboembolism. *A.M.A. Arch. Surg.* 65:31-36 (July) 1952
- <sup>7</sup>Barker, W. F.: The management of venous thrombosis and pulmonary embolism. *Surgery* 45:198-203 (Feb.) 1959
- <sup>8</sup>Dale, W. A.: Ligation of the inferior vena cava for thromboembolism. *Surgery* 43:24-44 (Jan.) 1958
- <sup>9</sup>Collins, C. G., and Ayers, W. B.: Suppurative pelvic thrombophlebitis. *Surgery* 30:319-328 (Aug.) 1951
- <sup>10</sup>Crane, C.: Deep venous thrombosis and pulmonary embolism. *New England J. Med.* 257:147-157 (July 25) 1957
- <sup>11</sup>Roe, B. B., and Goldthwait, J. C.: Pulmonary embolism; statistical study of post-mortem material at Massachusetts General Hospital. *New England J. Med.* 241:679-686 (Nov. 3) 1949
- <sup>12</sup>Robinson, J. R., and Moyer, C. A.: Comparison of late sequelae of common and superficial femoral vein ligations. *Surgery* 35:690-697 (May) 1954
- <sup>13</sup>Nabatoff, R. A.: Discussion of Dale<sup>8</sup>



## THE WOMEN'S STATE CYTOLOGY PROGRAM\*

### A Progress Report

JOSEPH SONG, M.D.; HERBERT FANGER, M.D.,  
AND THOMAS H. MURPHY, M.D.

The Authors. *Joseph Song, M.D., Associate Director, State Cytology Program, and Assistant Pathologist, Rhode Island Hospital; Herbert Fanger, M.D., Pathologist, Rhode Island Hospital; Thomas H. Murphy, M.D., Medical Director, Division of Cancer Control, Rhode Island State Health Department.*

THE UNIVERSITY OF TENNESSEE in conjunction with the National Cancer Institute has recently studied the incidence of cancer of the genital tract in a large population group detected by exfoliative cytology with confirmatory biopsy.<sup>1</sup>

Intraepithelial carcinoma of the cervix or invasive cancer was detected in 627 women of the first 95,000 examined (0.78%). Almost 5 in 1,000 (0.47%) of all women examined in the first screening had unsuspected disease. In an attempt to evaluate the incidence of genital tract cancer in different population groups, the National Cancer Institute is supporting similar studies in Providence, Rhode Island; Columbus, Ohio; Louisville, Kentucky; Detroit, Michigan, and a few other places throughout the country. The following is a report of the results of the first 25,000 cases examined in the state of Rhode Island. The state has a large adult female population ranging from 225,000 to 250,000 women who are over 20 years of age, 98.5% of them being white, the remaining 1.5% being non-white.

#### Materials and Methods

The routine procedures for this project consist of a vaginal fluid smear aspirated from the posterior fornix and a smear made by scraping material from the cervical os with a wooden spatula. As a rule, the routine vaginal smear taken from the posterior fornix of the vagina has great applicability to mass screening as demonstrated by the Memphis project. It is also believed that the percentage of positive findings can be increased by making additional smears with the cervical scraping method.<sup>2</sup> There are approximately 360 physicians who are participating in this project, and they were instructed to take the vaginal aspiration smear first followed by a scraping smear. All the specimens

are prepared by the physicians. None of them is made by the nurses or technical personnel. Additional specimens are available from ten clinics which are being established for the project. Dual smear examinations are routinely performed on all cases and both types of smears are screened by separate groups of people, checked by the senior checker, and rechecked by pathologists. The project has concentrated its efforts on obtaining both types of smears from asymptomatic women and has urged physicians to submit smears taken from suspected cases or women with known carcinoma of the genital tract to hospital cytology laboratories in the state. The pathologists of Rhode Island have kindly made available the biopsy specimens for examination. Our laboratory performs step serial sections on all cone biopsies and other selected cases. A comparison has been made of the accuracy and efficiency of both types of smears on all carcinoma-in-situ cases, invasive carcinoma of the cervix, and adenocarcinoma of the fundus. The results of the study have been rechecked by experienced checkers and finally examined by pathologists. The following data show the results of the project.

TABLE I  
Cytology Findings in 25,000 Cases

Positive (biopsy recommended).....	288 (1.1%)
Suspicious (repeat smear requested).....	220 (0.8%)
Atypical.....	2,942 (11%)
Unsatisfactory.....	550 (2.2%)
Negative.....	21,000 (84%)

TABLE II  
Biopsy Results in 25,000 Cases

Biopsy recommended.....	288
Ca-in-situ of Cx. ....	148
Squamous Cell Ca. ....	28
Adenocarcinoma of Fundus.....	19
Squamous Cell Ca. of Vagina.....	6
Carcinoma of Ovary.....	1
Borderline lesion of Cx. ....	23
Atypical Hyperplasia of Cx. ....	10
Biopsy Inadequate.....	4
Biopsy Negative.....	21
Biopsies to be Performed.....	28

Three pathologists independently reviewed all biopsy specimens of the cervix which were diagnosed as carcinoma-in-situ, borderline lesions, or atypical hyperplasia. A diagnosis of carcinoma-in-

\*Presented at the 148th Annual Meeting of the Rhode Island Medical Society, at Providence, Rhode Island, May 13, 1959.



THE WOMEN'S STATE CYTOLOGY PROGRAM

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TABLE III

Cytology Readings (Ca-in-situ)

148 Cases

Classification	CS Pos. VA Neg.	CS Pos. VA Atyp.	CS Pos. VA Susp.	CS Pos. VA Pos.	CS Neg. VA Pos.
Number of Cases	30	15	26	68	9

situ was made only if there was unanimous agreement. *Borderline lesions* were those cases suspicious of carcinoma-in-situ but lacking unanimity of diagnosis by the pathologists.

Table III compares the diagnosis made with the two cytologic techniques in cases proved to be carcinoma-in-situ by biopsy. It is evident that the cervical scraping smear detected more cases of tumor than the vaginal aspiration smear. In 45 cases only the cervical scraping smear enabled a diagnosis of cancer. However, in the majority of cases (94), both techniques detected cancer. In a small number of cases (9), only the vaginal aspiration smear demonstrated abnormal cells.

In the following table, there is similarity demonstrated in an increased number of cases of squamous cell carcinoma of the cervix detected by the cervical scraping smear and by the vaginal aspiration smear.

TABLE IV

Cytology Readings

Squamous Cell Carcinoma of Cervix

28 Cases

Classification	CS Pos. VA Neg.	CS Pos. VA Pos.	CS Neg. VA Pos.
Number of Cases	6	19	3

TABLE V

Cytology Readings

Adenocarcinoma of Fundus

19 Cases

Classification	CS Pos. VA Neg.	CS Pos. VA Neg.	CS Neg. VA Pos.
Number of Cases	4	10	5

Table V shows the results of the study on 19 cases of adenocarcinoma of the fundus. Both techniques were similarly detected.

Table VI shows the distribution of the age incidence of carcinoma-in-situ in our series. The youngest case was 22 years of age. The findings were similar to the results of the University of Tennessee.

TABLE VI

Age Incidence of Carcinoma-in-situ

148 Cases

Age	10-20	21-30	31-40	41-50	51-60	61-70	71-
Number of Cases	None	17	68	36	18	9	None

Table VII shows the age incidence of squamous cell carcinoma. It should be noted that the age incidence in squamous cell carcinoma tends to be higher than in carcinoma-in-situ.

TABLE VII

Age Incidence of Squamous Carcinoma

28 Cases

Age	10-20	21-30	31-40	41-50	51-60	61-70	71-
Number of Cases	None	None	3	9	12	2	2

The following table lists the type of biopsy specimens which were submitted in the cases of carcinoma-in-situ. These were examined by step serial sections; every tenth section was stained.

TABLE VIII

Type of Biopsy

Carcinoma-in-situ

148 Cases

Cervical Cone	92
Cervical Biopsy	56

Table IX lists the number of cases of residual carcinoma-in-situ found upon hysterectomy after the initial cone biopsy. The demonstration of residual carcinoma in 11 of 55 cases examined is impressive.

TABLE IX

Residual Carcinoma-in-situ

Subsequent Hysterectomy	55
Residual Ca-in-situ	11
No Residual Ca-in-situ	44

Despite the dual smear technique, a small number of false-negative cases occurred which seems inevitable in a mass screening survey. Table X lists the false-negative cases.

TABLE X

False Negatives

Adenocarcinoma of Fundus	6
Squamous Cell Carcinoma of Cervix	3

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DERMATOLOGISTS ELECT

At the annual meeting of the Rhode Island Dermatological Society, held May 27, the following officers were elected:

*President:* BENCEL L. SCHIFF, M.D., of Pawtucket  
*Secretary-Treasurer:* LOUIS LEVINE, M.D., of Providence

## PRIMARY PSYCHIATRIC DISORDERS ON A DEPENDENT MEDICAL SERVICE IN A MILITARY HOSPITAL WITH SPECIAL EMPHASIS ON CONVERSION REACTIONS\*

LT. ALFRED W. WOLFSOHN, MC, USNR, AND

LT. FREERK W. WOUTERS, MC, USNR

THE AUTHORS' ATTENTION was focused upon the relatively high incidence of primary psychiatric discharge diagnoses on patients admitted to the dependent medical service of a 500-bed U.S. Naval Hospital. The admission of three cases of astasia abasia within a fortnight drew attention particularly to the occurrence of conversion reactions in their more classic manifestations.

During a twelve-month period there were 320 medical admissions of adult female dependents. Thirty-six (11%) were found to have primary psychiatric disorders. Of these, eighteen (50%) were diagnosed as hysterical personalities according to the criteria outlined by Chodoff.<sup>1</sup> A total of eleven (31%) patients having conversion reactions was found among the entire psychiatric group. Nine of these were considered secondary to hysterical personalities. Thus fifty per cent of hysterical personalities presented with conversion reactions. In addition, in the total psychiatric group there were ten (28%) attempted suicides, only one of whom was considered a serious attempt.

It is generally believed that conversion hysteria occurs less frequently today than it did fifty years ago. This is particularly true of the more classical forms of conversion reaction. It is certainly diagnosed less frequently than formerly but whether this is due to a real or an apparent decline in its incidence is less obvious.<sup>2</sup>

The following cases illustrate some of the clinical manifestations encountered.

### *Case One*

K.P., a fourteen-year-old single Caucasian female, was admitted with a diagnosis of paraplegia. Her initial physical examination was within normal limits with the exception of an inability to stand without support and a striking "La Belle Indifference." She began improving immediately after admission and was asymptomatic within forty-eight hours.

The patient was the older of two siblings of her mother's first marriage. There were two children

\*From the Departments of Medicine and Psychiatry, United States Naval Hospital, Newport, Rhode Island.

The opinions expressed are those of the authors and do not necessarily reflect the views of the Department of the Navy.

born of the present marriage. The mother had a subdural hematoma in 1954. Since that time she has been impulsive, labile emotionally, and at times physically aggressive toward the patient, without apparent provocation. In addition, the twelve-year-old stepbrother, who is the preferred child of the mother, was hospitalized in a state hospital for a period of six months because of "aggressive behavior." Considerable marital discord exists at the present time. There is a great deal of drinking and physical altercations have occurred to the extent that the civil authorities have seen fit to intervene on several occasions.

### *Case Two*

J.R., a twenty-three-year-old married Caucasian female, was brought into the admission room complaining of severe shortness of breath. This followed an episode of fainting. The patient described this as typical of her "asthmatic attacks." She then proceeded to act as if she were in labor having regular rhythmic pains, tossing restlessly upon the examination table and responding poorly to verbal stimuli. Her past history revealed that she was born and reared in rural South Carolina. She was the oldest of four siblings. Her parental home was unhappy. Her father, a salesman, overindulged in alcohol and engaged in numerous verbal and physical quarrels with her mother. The patient received a high school education. She attended one year of junior college. She then married and left school. She states that she married in order to escape a premarital affair which had been going on for the previous four years. The marriage was described as relatively happy until the birth of her second child eight months prior to admission. With the last child, labor had to be induced and sedation was quite restricted as the quality of her labor pains was poor. Since that time she has dreamed repeatedly about this labor. She has developed marked feelings of hostility to physicians, blaming them for her painful labor. She has become frigid and increasingly resentful toward her husband. She mistook him for her obstetrician during the episode in the admission room. On admission, aside from hyperventilation, the physical examination and laboratory studies were all entirely within normal limits. She com-

plained of severe weakness for the first twenty-four hours of hospitalization, after which she became totally asymptomatic.

### Case Three

J.S., a twenty-five-year-old married Caucasian female, was admitted to the hospital because of persistent nausea and vomiting over a ten-month period. She lost fifty pounds in weight and had restricted visual fields, crying spells and insomnia. She failed to respond to various medications including chlorpromazine and prochlorperazine. The patient had been unable to conceive since her marriage five years prior to admission. Upon missing her period twelve months prior to admission she consulted a physician who told her she was pregnant. At the next visit she was told that this was not so and within twenty-four hours commenced vomiting a short while after each meal. Her amenorrhea has persisted despite attempts to induce menstruation by estrogens. In addition to the foregoing symptoms, the patient complained about asthenia, emotional outbursts and frequent anxiety dreams.

History revealed that the patient was the youngest of three siblings. Her father was an outgoing active person who indulged in numerous extramarital affairs during the patient's childhood. When she (the patient) was in high school, he divorced her mother without apparent reason. The father subsequently became a licensed lay minister. Previously he had been a factory representative earning a considerably better than average income. The mother is described as a very quiet, uncomplaining person who accepted her husband's impulsiveness without comment. The patient's birth and early development were not remarkable. At the age of twelve she was hospitalized for a period of seven months with an eosinophilia reputed to have reached 70,000. The patient's parents were told at that time that she had leukemia, but all symptoms disappeared without treatment. She did well in high school until her parents were divorced, at which time she became quite upset and depressed. Subsequently she attended college for two years and then became a registered medical technician. She met her husband while in college and married him shortly after her graduation. The marriage is described as a relatively happy one and the husband has displayed considerable insight into his wife's difficulties.

After admission all studies, including a complete neurological evaluation, failed to reveal any organic basis for the patient's illness. Psychological tests revealed a pattern consistent with a conversion reaction.

### Comments

The three cases presented illustrate conversion reactions occurring in patients with various back-

grounds. The first case presents the usual picture cited as typical of the present day pattern. The second and third cases represent the occurrence of conversion reactions in more sophisticated personalities. The third case is particularly impressive when the life endangering quality of the patient's weight loss is considered.

### SUMMARY

The high incidence of psychiatric discharge diagnoses in the female medical ward of a Naval Hospital is stressed. The hysterical personality was the most prevalent type of disorder found. Since it manifested itself in various ways it was often considered to be a medical admission. The initial manifestations included conversion reactions, dissociative states and attempted suicide. The often encountered classical appearance of a conversion picture is noteworthy. This is of interest not only to the psychiatrist who is ultimately consulted in these cases, but also to the internist and family doctor who is faced with the initial diagnosis and early care of the patient.

### BIBLIOGRAPHY

<sup>1</sup>Chodoff, P., and Lyons, H.: Hysteria, the Hysterical Personality and "Hysterical" Conversion. *The American Journal of Psychiatry*, 114:734-740, February 1958

<sup>2</sup>*Ibid*



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## FREE CHOICE AND CLOSED PANELS

THE QUESTIONS of free choice of physician, and of participation in panel types of service received thorough review and discussion by American medicine in the past few months. The important sections of the report of the Commission on Medical Care Plans of the American Medical Association, reprinted in the March, 1959, issue of our Journal, called for action by each constituent state association.

It is interesting to note that the action of our House of Delegates on these two major topics was in keeping with what turned out to be a national expression of opinion expressed by the House of Delegates of the A.M.A. at the Atlantic City meeting in June.

The A.M.A. House adopted thirty-six of the recommendations in the Commission's report, and reworded three, one of which was adopted as follows:

(B-16). "The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses. Each individual should be accorded the privilege to select and change his physician at will, or to select his preferred system of medical care, and the American Medical Association vigorously supports the right of the individual to choose between these alternatives."

The A.M.A. House also requested the Board of

Trustees to transmit to all the state associations the far-reaching significance of the recommendation stating—

" 'Free choice of physician' is an important factor in the provision of good medical care. In order that the principle of 'free choice of physician' be maintained and be fully implemented, the medical profession should discharge more vigorously its self-imposed responsibility for assuring the competency of physicians' services and their provision at a cost which people can afford."

The House also strongly endorsed the recommendation declaring that

"Those who receive medical care benefits as a result of collective bargaining should have the widest possible choice from among medical care plans for the provision of such care."

The complete report of the actions of the A.M.A. House of Delegates is published in the JOURNAL OF THE A.M.A. Certainly the impact of the national legislative policies upon every practicing physician warrants a complete reading by him of these transactions, the highlights of which we have briefly noted.

## MEDICAL PRACTICE IN SOVIET RUSSIA

Published elsewhere in this issue is a fascinating account of the practice of medicine in present-day Russia. Two observations are noteworthy: that an inadequate supply of well-trained physicians is

supplemented by a group of sub-professional "feldschers," hardly more than orderlies or corpsmen, and that the ideals of Western Hippocratic medicine are subordinated to the needs of a state whose political militancy overrides all personal considerations. It is of interest that the feldscher\* is not an innovation of the Soviet regime, but was a fixture on the Russian scene in the days of the Czars. Some of the Russian-Jewish immigrant doctors in America trained in Europe around the turn of the century were recognized by their more sophisticated contemporaries to be feldschers.

The most important concept which this paper develops is that the planning and training for all classes, physicians included, is on a long-term survival basis. The vast country is organized to facilitate with a minimum of impact upon the economy and social organization the shift from peace to war and from war to peace.

\*Translation: *leech*

### FOR DISTINGUISHED SERVICE

Only those persons closely allied to the medical profession are truly aware of the notable contributions, over and above the demands of medical practice, that are made by physicians in the interest of community services. We doubt that many persons are even aware of the time that is given willingly by doctors as members of the many committees of their medical associations which seek to contribute to the general welfare of the entire community.

Therefore, all our membership may be said to share in the honors bestowed on Doctor Alex M. Burgess, Sr., and Doctor A. A. Savastano by Rhode Island colleges within the past month.

Doctor Burgess, internist, community leader and educator, to list but a few of his accomplishments, was cited by the Rhode Island College of Education at its commencement exercises for his outstanding career which has not only left its mark upon this state, but has been worldwide in its impact. Former governor, regent and vice president of the American College of Physicians, member and vice chairman of the Joint Commission on Accreditation of Hospitals, and currently director of medical education at three major general hospitals in Rhode Island, Doctor Burgess still finds the time and energy to embark on new programs at an age when most persons would be content to sit back and relax.

In honoring Doctor Americo A. Savastano, Providence orthopedic surgeon, the University of Rhode Island paid highest tribute to one of her own alumni. A graduate of Harvard Medical School, Doctor Savastano completed his preliminary training in New York, specializing eventually in orthopedics before returning to Providence to establish his practice. A devoted and loyal alumnus, Doctor Savastano has been particularly active in the pro-

motion of the educational programs of the University, of which the symposium on the prevention and treatment of athletic injuries which will attract physicians from all parts of the nation to Kingston this August, is a fine example.

The *JOURNAL* salutes Doctors Alex Burgess and Americo Savastano for the new honors accorded them by our state colleges in recognition of their distinguished service as physicians and as citizens.

### BEEN FOR A WALK LATELY?

With the advent of the summer season with its long days and good weather, outdoor physical activity in its many forms claims the attention of an American public that for the most part has become accustomed to taking its exercise sitting down watching others in motion.

We see golfers driving distances to play their favorite sport, and some even then riding about the course in a mechanized golf cart. On the other hand, we see persons who have led a sedentary life for fifty weeks of the year indulging in the most strenuous exercise in the long-awaited two-week vacation time.

What we see the least of these days is people strolling at a leisurely pace either in a favorite woods or along a tree-shaded street. One of our best liked physician friends tells us that he and his wife have taken evening walks during the past several months in a local residential neighborhood and they are amazed to find that they encounter not a single person afoot in their travels.

A walk around the block, or in the park, used to be a favorite family pastime on a Sunday afternoon, or on a summer evening. Not only did the stroller get needed exercise, but he also had a chance to meet friends and neighbors, to observe at firsthand, and leisurely, scenes that vanish all too quickly from the sight of the speeding motorist.

Not long ago two young men walked from Los Angeles to Mexico City, some two thousand miles. We wouldn't advocate such a jaunt for anyone. But we do believe that walking is far from a lost art, in spite of the convenience of the automobile, and we hope we do not espouse a losing cause when we urge our readers to remind themselves of the pleasures they experienced in years past by walking. We hope that more of our friends will rediscover the fun that is gained from walking, not just to reach a destination, but for the pleasure and healthy exercise gained.

### ATHLETIC INJURIES

The two-day symposium on the prevention and treatment of athletic injuries, to be held at the University of Rhode Island August 17-18, marks another "first" for the state, for it will be the first time that this type of a health conference has been held in New England.

*concluded on next page*

Aimed to offer a broad and intensive review of present-day concepts of the prevention and care of injuries sustained in athletic competition, the symposium promises to attract a large number of physicians, athletic trainers and coaches from the entire eastern regions of the country. No little credit for the idea of such a conference, and the planning of the program, is due to Doctor A. A. Savastano, of Providence.

The surprising factor to us as we review the interesting program of lectures, panel discussions and demonstrations planned for the meeting at Kingston is that this type of conference had not been considered and developed years ago. Competitive scholastic and collegiate athletics have become highly organized in the past two decades, and although most schools undoubtedly conduct their athletic programs with some medical supervision, the opportunity for those directly concerned with the problems of athletic injuries to discuss preventive and curative procedures has been lacking.

While the symposium at the University of Rhode Island next month will warrant particular attention by doctors who are directly concerned with the care of athletes, yet for all physicians it offers a most informative postgraduate conference locally on medical problems encountered in general practice.

## THE WOMEN'S STATE CYTOLOGY PROGRAM

*concluded from page 449*

Table XI demonstrates the value of the screening survey.

TABLE XI  
Value of Screening Survey

Type of Cancer	Number of Confirmed Cases	Number of Suspected Cases	Number of Unsuspected Cases
Ca-in-situ of Cx.	148	11	137 (92%)
Invasive Ca. of Cx.	28	15	13 (46%)
Adenocarcinoma of Fundus	19	8	11 (55%)

98.5% of the smears were taken from white females and 1.5% from the non-white female population in the state of Rhode Island. One case of carcinoma-in-situ was found in a negro patient, and the remaining 147 cases were found in white patients. All cases of invasive carcinoma and adenocarcinoma of the fundus were found in white females.

## SUMMARY AND COMMENT

1. The dual smear examinations (vaginal aspiration and cervical scraping smears) in a subsidized screening survey for uterine cancer are considered to be highly effective in the detection of carcinoma of the cervix and adenocarcinoma of the fundus. Continued examinations of both types of smears seem justified, since both specimens have a definite diagnostic value.


2. Results of the study of cervical cone biopsy specimens and subsequent hysterectomy specimens suggest that cervical cone biopsy is not satisfactory as a therapeutic procedure since there were a considerable number of residual carcinoma-in-situ cases found in hysterectomy specimens.

## REFERENCES

- <sup>1</sup>Erickson, C. C.; Everett, B. E., Jr.; Graves, L. M.; Kaiser, R. F.; Malmgren, R. A.; Rube, I.; Schreier, P.; Cutler, S. J.; and Sprunt, D.H. J.A.M.A. 162:167, 1956
- <sup>2</sup>Simon, T. R.; Durfee, G., and Ricci, A.: Transactions of Third Annual Meeting of the Inter-Society Cytology Council

## TASTY-MONIALS

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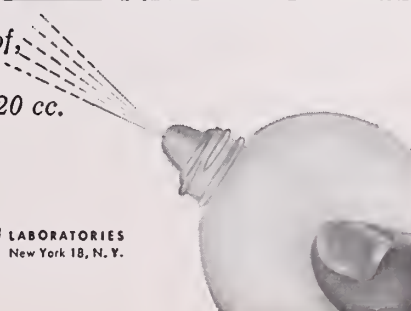
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## REPORT ON THE ACTIONS OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION AT THE 108th ANNUAL MEETING

at Atlantic City, New Jersey, June 8-12, 1959

CHARLES J. ASHWORTH, M.D., *Delegate*

ARTHUR E. HARDY, M.D., *Secretary*

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RECENT INTEREST of members of the Rhode Island Medical Society in compulsory social security coverage for self-employed physicians, as evidenced by a poll of the membership, the final tabulation of which is not yet complete, alerted your delegate to the action of the House of Delegates of the American Medical Association at its 108th meeting in Atlantic City. Five resolutions on this subject were introduced by various delegations, four of which urged the American Medical Association, through its House of Delegates, to go on record as approving compulsory social security coverage for self-employed physicians, whereas one urged the delegates to continue in their opposition to such proposals. The Reference Committee, to which these resolutions were assigned, recommended to the House of Delegates reaffirmation of past and present opposition to the compulsory inclusion of physicians, and the House unanimously approved the Reference Committee's recommendation.

Concern over the possible effects that such a change of policy might have on the American Medical Association's entire legislative program, particularly with respect to the Forand and similar bills, unquestionably influenced the Committee's recommendation and the subsequent action of the House. The Reference Committee, however, did suggest "that the American Medical Association continue to expand its educational program to inform its members of the economic, social, and moral advantages of economic security obtained within the framework of our free enterprise system, rather than through the mechanisms of governmental social security." The growing demand by physicians for economic security was made apparent to the House and resulted in a request to the Board of Trustees to look into the possibilities of developing group and retirement plans suitable and available to members of the American Medical Association. Except for the states in the Northeastern area of the country, opposition to compulsory social security for self-employed physicians was pretty well solidified, as evidenced by the opinions presented by the various state delegations to the Reference Committee.

### *Commission on Medical Care Plans*

The House of Delegates received Part I of the report of the Commission on Medical Care Plans as information only and then acted upon the Commission recommendations item by item. The House adopted 36 of the recommendations without change, but reworded three which relate to miscellaneous and unclassified plans. The changed recommendations now read as follows:

B-4. "In an effort to decrease, or at least to prevent an increase, in the over-all cost of health care, study should be given to the removal of the requirement of hospital admission as the only condition under which payment of certain benefits will be made."

B-6. "Medical care plans should be encouraged to increase their efforts to provide health education and information concerning the coverage of their subscribers."

B-16. "The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses. Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care and the American Medical Association vigorously supports the right of the individual to choose between these alternatives."

In connection with free choice of physician, the House also requested the Board of Trustees to transmit to all constituent medical associations the "far-reaching significance" of Recommendation A-7, which says:

"'Free choice of physician' is an important factor in the provision of good medical care. In order that the principle of 'free choice of physician' be maintained and be fully implemented, the medical profession should discharge more vigorously its self-imposed responsibility for assuring the competency of physicians' services and their provision at a cost which people can afford."

The House also strongly endorsed Recommendation B-11, which declares that "Those who receive medical care benefits as a result of collective bargaining should have the widest possible choice from

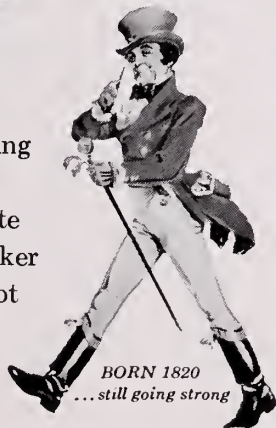
*continued on page 458*



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## A.M.A. HOUSE OF DELEGATES

*continued from page 456*

among medical care plans for the provision of such care."

Many of the Commission recommendations urged increased activity by state and county medical societies and the American Medical Association in such fields as continuing study and liaison, closer attention to legal and legislative factors, and the development of guides for the relationship between the medical profession and the various types of third parties. To carry out three of the recommendations involving A.M.A. activities, the House also approved a seven-point program which it requested the Board of Trustees to transmit to the Division of Socio-economic Activities for immediate attention.

*Medicine and Osteopathy*

In considering a special report of the Judicial Council on the subject of osteopathy, the House adopted the following policy statement regarding interprofessional relations:

"(A) All voluntary professional associations between doctors of medicine and those who practice a system of healing not based on scientific principles are unethical.

"(B) Enactment of medical practice acts requiring all who practice as physicians and surgeons to meet the same qualifications, take the same examinations and graduate from schools approved by the same agency should be encouraged by the constituent associations.

"(C) It shall not be considered contrary to the Principles of Medical Ethics for doctors of medicine to teach students in an osteopathic college which is in the process of being converted into an approved medical school under the supervision of the A.M.A. Council on Medical Education and Hospitals.

"(D) A liaison committee be appointed by the Board of Trustees of the American Medical Association to meet with representatives of the American Osteopathic Association, if mutually agreeable, to consider problems of common concern including inter-professional relationships on a national level."

In another action concerning osteopathy, the House recommended that the American Medical Association representatives on the Joint Commission Accreditation of Hospitals suggest to the Joint Commission that they inspect upon request and consider for accreditation without prejudice those hospitals required by law to admit osteopathic physicians to their staff.

*Preparation for General Practice*

The House approved and commended the final report of the Committee on Preparation for General Practice, which proposes a new two-year in-

ternship program for medical school graduates planning to become family physicians. To avoid unnecessary confusion, the House deleted only one sentence which read: "Indeed, the committee believes that the one-year internship actually encourages inadequate preparation for general practice." The Committee on Preparation for General Practice included representatives from the A.M.A. Council on Medical Education and Hospitals, the American Academy of General Practice and the Association of American Medical Colleges.

The suggested program would include a basic minimum of eighteen months hospital training in the diagnostic, therapeutic, psychiatric, preventive and rehabilitative aspects of medicine and pediatrics in a very broad sense, including care of the newborn. A physician then could elect to spend the remaining six months for additional training in other segments of the program. The committee stated, however, that participants who plan to practice obstetrics would be expected to spend at least four months of the elective period in obstetrical training.

The report declared that "the graduate program of two years in preparation for family practice should be planned and implemented as a unified whole" with a maximum continuity of assignment in specific services. The program also calls for adequate experience in out-patient care and emergency room service.

*Miscellaneous Actions*

In dealing with a wide variety of other subjects, the House also: Urged all physicians to participate more fully in community activities and *socio-economic matters* in their own communities but agreed that no change should be made at this time in Article II of the Constitution, which states Association objectives.

Approved in principle the aims and objectives of the President's Council on *Youth Fitness* and the Citizens Advisory Committee on the Fitness of American Youth;

Accepted a Board of Trustees recommendation that the 1962 *Annual Meeting* be held in Chicago;

Expressed heartfelt thanks to the Committee on *Amphetamines* and *Athletes*, which has completed its assignment;

Requested the Board of Trustees to study the problems and possibilities of establishing an A.M.A.-sponsored *medical scholarship* and/or loan program;

Approved the inclusion of *Today's Health* as a benefit of dues-paying membership and urged members to make it available to their patients;

Recommended that state medical societies, where advisable, initiate legislative efforts to eliminate *cancer quackery*;

*concluded on page 460*



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## A.M.A. HOUSE OF DELEGATES

*concluded from page 458*

Received a progress report indicating "phenomenal progress" in the field of health insurance coverage for *the aged* since the Minneapolis meeting last December;

Gave a rising vote of thanks to *Dr. Joseph D. McCarthy*, who finished his term as chairman of the Council on Medical Service;

Reaffirmed its full support of the Educational Council for *Foreign Medical Graduates*;

Endorsed the purposes outlined in the initial report of the *Medical Disciplinary Committee*;

Urged every A.M.A. member to give a substantial gift to the *medical schools* through the American Medical Education Foundation; and

Expressed appreciation for the outstanding *disaster medicine* program presented by the United States Army Medical Service on June 6, 1959, in Atlantic City.

The appearance of President Dwight D. Eisenhower, who addressed an overflow audience of more than 5,000 at the Tuesday night inauguration of Dr. Louis M. Orr of Orlando, Florida, as the 113th president of the A.M.A.; marked the first time that a President of the United States has addressed an A.M.A. annual or clinical meeting.

President Eisenhower warned that inflation posed the greatest danger to the traditional, free enterprise practice of medicine. The cost of inflation, he said, "is not paid in dollars alone but in increasingly stagnated progress, lost opportunities, and eventually, if unchecked, in lost freedoms for the doctor and the patient." Mr. Eisenhower also expressed gratification at learning of A.M.A. leadership in the program to meet the nation's health care needs.

Dr. E. Vincent Askey of Los Angeles, speaker of the House of Delegates since 1955, was named president-elect for the coming year. Dr. Askey will succeed Dr. Orr as president at the association's annual meeting in June, 1960, in Miami Beach.

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The 1959 Distinguished Service Award of the American Medical Association was voted to Dr. Michael E. De Bakey of Houston, Texas, chairman of the department of surgery at Baylor University College of Medicine, for his outstanding contributions in the field of cardiovascular surgery.

Dr. Orr, in his inaugural address, affirmed his belief in the basic principles of medicine, democracy and faith under which America's physicians live. He pointed out that freedom must continually be fought for by men and women who are willing to stand up and be counted. Dr. Leonard Larson of Bismarck, N. D., A.M.A. Board Chairman, administered the oath of office to Dr. Orr. The Fort Dix Band Chorus presented the musical program.

In addition to Dr. Askey, the new president-elect, the following officers were selected at the Thursday session;

Vice president, Dr. James Stanley Kenney of New York City; speaker of the House of Delegates, Dr. Norman A. Welch of Boston, and vice speaker, Dr. Milford O. Rouse of Dallas, Tex.

Dr. R. B. Robins of Camden, Ark., and Dr. Hugh H. Hussey, Jr., of Washington, D. C., were re-elected for five-year terms on the board of trustees. Also elected to the board, for the first time, was Dr. Percy E. Hopkins of Chicago.

Dr. J. M. Hutcheson of Richmond, Va., was re-elected to the Judicial Council. Re-elected to the Council on Medical Education and Hospitals were Dr. Charles T. Stone, Sr. of Galveston, Tex., and Dr. W. Andrew Bunten of Cheyenne, Wyo.

Dr. Willard Wright of Williston, N. D., was elected, and Dr. J. Lafe Ludwig of Los Angeles was re-elected to the Council on Medical Service. Dr. William Hyland of Grand Rapids, Mich., was re-elected to the Council on Constitution and By-laws.

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## PUBLIC LAWS . . . 1959

## SUMMARY OF MEDICAL, PUBLIC HEALTH AND ALLIED LEGISLATION

Before the Rhode Island General Assembly, January Session, 1959

THE COMMITTEE on Public Laws of the Society carefully reviewed all legislation presented to the General Assembly during the 1959 session. Legislation inimical to public health and tending to lower or weaken in any way the standards for the best protection of the public was vigorously opposed. One bill in particular which would have allowed chiropractic physicians to treat recipients of public assistance for all their medical needs was passed by the Assembly in spite of the Society's opposition and that of the state departments of social welfare and of health. Governor Del Sesto vetoed the bill when it reached his desk.

With the Senate and House controlled by the Democratic party, and the Governor the lone Republican officer, some of the legislation enacted apparently was intended to force the Governor to exercise his power of veto. It is to be regretted that more public hearings were not held on various legislative proposals, and that greater support is not given to those who oppose legislation not in the best interest of the public.

A summary of the action on legislation in which the Society's committee on public laws expressed a particular interest follows:

*Passed and Signed by the Governor*

Among the acts passed and signed by the Governor were ones that created a special legislative commission to investigate the distribution and use of harmful and dangerous chemicals; that would provide a chemical test for drunken driving cases which would be admitted as evidence provided that certain conditions had been complied with; that would regulate the possession, handling, control, dealing in sale and distribution of food, drugs, cosmetics, amending the present Food and Drug Act; that would give \$631,770 toward the support of the general hospitals of the state; and that would raise the salary of the chief medical examiner to \$15,000, and would also provide for a third medical examiner in the greater Providence area.

Also signed by the Governor were bills that would incorporate the Rhode Island Higher Education Assistance Corporation to aid students with the costs of college education; that would authorize the state to participate in the New England board

of higher education regional plan for medical-dental education, for which \$14,500 was appropriated; that would permit milk dealers to standardize milk by adding skimmed milk or cream; that would regulate advertising by optometrists; and that would establish a uniform fire code or drill tactics for the safety of school children.

Workmen's Compensation bills signed by the Governor included ones that would require the employer to pay the fee of any employee's examining physician, that would increase the allowance for burial expenses by \$250, and that would provide that if stiffness or uselessness of a specific bodily member is less than total, then compensation shall be paid for such period of weeks proportionate to the period applicable in the event the appendage had been completely severed. Also signed was a bill that raises the maximum to \$62 for the combined benefits of workmen's compensation and temporary disability compensation for an injured employee.

Two memorial resolutions were adopted by the General Assembly paying tribute to the late Doctor Michael H. Sullivan of Newport, and the late Doctor Francis V. Garside of Providence.

*Passed by the Assembly, Effective Without the Signature of the Governor*

In addition to a resolution memorializing the Congress of the United States relative to providing free medical care to aged persons (the Forand bill) which was introduced in the Senate April 16, passed without discussion, and received similar treatment in the House the following day, the Governor allowed to become effective without his signature the bill permitting milk dealers to use a registered trade-mark, brand or brand name in the labels of milk containers, and a bill that would allow the incorporation of a nonprofit dental service corporation.

*Vetoed by the Governor*

Two proposals to provide Blue Cross and Physicians Service coverage for state employees at state expense included legislators, and others not considered full-time state employees, and which would start the program before the state had the available funds, had to be vetoed by the Governor.



A bill that would allow chiropractic physicians to give medical care to public assistance beneficiaries, opposed by the state health and social welfare departments, as well as the Rhode Island Medical Society, in public hearing that left little doubt as to the inadequacy of chiropractors to render such service, was pushed through the General Assembly the final night of its session, and it was subsequently vetoed by Governor Del Sesto.

Also vetoed after their enactment by the Assembly were bills that would create a legislative commission to consider the status of confidential communications and information in certain circumstances, and to determine the feasibility of enacting legislation in reference thereto; that would create a legislative commission to determine if, in the light of modern psychiatric knowledge, new standards for determining mental irresponsibility for criminal behavior in Rhode Island should be promulgated; and that would amend the medical service corporation statute to include chiropodists as physicians.

#### *Health Legislation Left in Committee Files*

Among legislative proposals left in committee files were the following:

To provide free medical and hospital care for widows of deceased veterans of World War I; to allow a \$19 per diem for hospital care of injured workmen's compensation beneficiaries; to place the supervision of nursing homes in the health department instead of the department of social welfare; to have a commission study the feasibility of merging the health and welfare departments; to have a commission study the feasibility of a state fund for workmen's compensation; to license social workers; to permit a statement of fact or opinion on a subject of science or art contained in a published treatise in a suit involving alleged malpractice against a physician to be used in evidence; to amend sections of the narcotics drug act; to make polio inoculations compulsory; to give the Tuberculosis League \$10,000 to help it clear its 1958 operating deficit, and to exempt, among others, physicians from jury duty.

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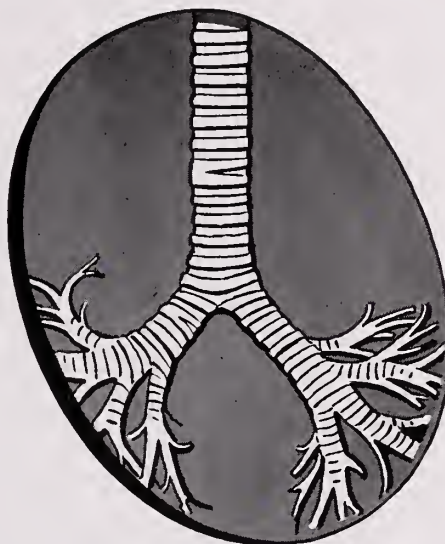
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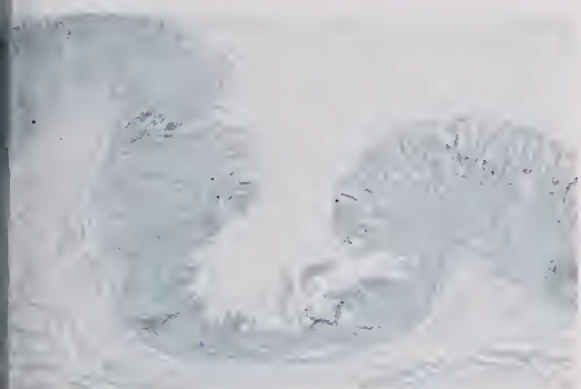
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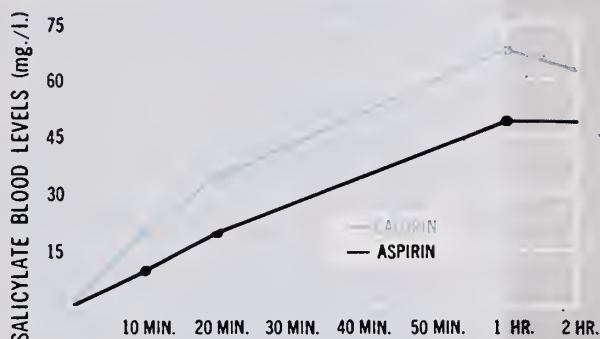
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**REFERENCES** 1. Waterson, A. P.: Aspirin and gastric haemorrhage, *Brit. M. J.* 2:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic observation of the effect of aspirin and certain other substances on the stomach, *Lancet* 2:1222, 1938. 3. Editorial Comments: The effect of salicylic acid (aspirin) on the gastric mucosa, *Canad. M. A. J.* 80:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, *Brit. M. J.* 2:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, *Lancet* 1:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, *Gastroenterology* 35, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, *New Eng. J. M.* 258:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, *New Eng. J. M.* 258:219, 1958. 10. Editorial: Aspirin plain and buffered, *Brit. M. J.* 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium salicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

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 Guyon Dupre, M.D.  
 Walter R. Durkin, M.D.  
 Louis J. Fuhrmann, M.D.  
 William J. MacDonald, M.D.  
 Alfred L. Potter, M.D.  
 William A. Reid, M.D.  
 Mildred Robinson, M.D.  
 Henry E. Turner, M.D.  
 John G. Walsh, M.D.

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Polio Foundation*

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 David J. Fish, M.D.  
 Henry S. Joyce, M.D.

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 Maurice W. Laufer, M.D.  
 Laurence A. Senseman, M.D.  
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 Eric Denhoff, M.D.  
 Ernest L. Dupre, M.D.  
 Herbert Ebner, M.D.  
 Thomas F. Head, M.D.  
 Gilbert Houston, M.D.  
 Rudolph A. Jaworski, M.D.  
 Maurice N. Kay, M.D.  
 Robert E. Martin, M.D.  
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 Earl J. Mara, M.D.  
 Samuel Nathans, M.D.  
 Robert Rosin, M.D.  
 Anna Sandberg, M.D.

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Richard P. Sexton, M.D., *Chairman*  
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 Raymond N. MacAndrew, M.D.  
 Ernest J. Quesnel, M.D.  
 Nathaniel D. Robinson, M.D.  
 Bencel Schiff, M.D.  
 Julius Stoll, Jr., M.D.

**COLLEGE OF PHYSICIANS . . .**

**Northeast and Eastern Canada Regional Meeting**  
**at Providence**

**Friday, October 23, and Saturday, October 24**

## DISTRICT MEDICAL SOCIETY MEETING

### PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, April 6, 1959. The meeting was called to order by the president, Doctor John C. Ham, at 8:30 P.M.

Doctor Ham announced that the minutes of the previous meeting would be published in the RHODE ISLAND MEDICAL JOURNAL and, therefore, they would not be read at the meeting unless there was a request for the reading.

Doctor Ham reported on meetings planned by the Rhode Island Heart Association on April 8, and the Rhode Island Medical Society on May 12 and 13, and on plans for the Annual Dinner and Golf Tournament of the Providence Medical Association on June 24. He also announced the plans of the Board of Lady Visitors of the Providence Lying-In Hospital for a musical concert on April 24, the profits from which would be used to purchase new equipment for the hospital.

#### *Nominations for Election to Membership*

Doctor Michael DiMaio reported that the Executive Committee had approved of the applications for active membership of the following physicians: Doctors Robert Howard Rosen, Jeremiah A. Dailey, Joseph E. Donahue, and Joseph S. Karas.

**ACTION:** It was moved that these doctors be elected to active membership. The motion was seconded and passed.

Leo A. Coleman, M.D.; Max Faintyck, M.D.; Manoel Falcao, M.D.; Wolfram H. Fischer, M.D.; Thomas E. Hunt, M.D., and Daniel Massouda, M.D.

**ACTION:** It was moved that these physicians be elected to active membership. The motion was seconded and adopted.

#### *Scientific Program*

The president introduced Doctor Herbert S. Sise, director, Circulation Laboratory, Boston City Hospital, who spoke on *Anticoagulants in Cardiovascular Disease*. Doctor Sise reviewed the current concept of the mechanics of coagulation.

He pointed out that anticoagulants failed to influence the death rate in pulmonary embolus because of the failure to recognize physical signs and/or because of the absence of physical signs. He said

that 45% of the cases of pulmonary embolus have no signs. Silent emboli occur frequently in the spleen and kidney.

The mortality rate in long-term anticoagulant treatment of myocardial infarction is three to five times less than in untreated cases.

Coumarin is not very helpful in long-term treatment. Heparin is the drug of choice for short-term anticoagulant effect because of its immediate action. In shifting from Heparin to Coumarin there must be an overlap of at least five days. Heparin by the intermittent intravenous route is favored by the speaker.

Patients should not be accepted for anticoagulant treatment unless every attempt has been made to make a diagnosis.

For long-term therapy following discharge from the hospital, anticoagulants must be decreased by about 25%; patients must be seen frequently at first, at least two to three times weekly; orothrombin time should be kept between 20 to 30 seconds.

#### *Presentation of Membership Certificates*

Doctor John C. Ham presented certificates of membership to the physicians elected at the March meeting of the Association.

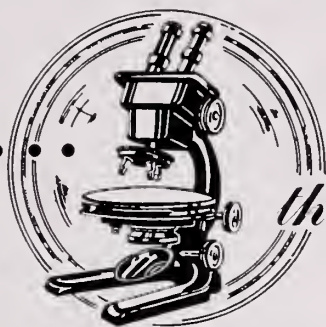
#### *Scientific Program*

Doctor Ham introduced Doctor Howard Reid Craig, New York Academy of Medicine, and Justice Aron Steuer, of the Supreme Court of the State of New York, who presented the medical and legal views on the *New York Medical Testimony Project*.

The speakers described the system used in New York in an attempt to expedite legal problems in injury cases. According to the New York system, a medical expert is appointed to make an examination of the injured person prior to the trial. The experience in New York has shown that in the vast majority of cases the medical aspect of the case is settled before the trial. This method has led to a rapid handling of injury cases.

The subject was discussed officially by Doctor John E. Donley, medical director, State Curative Center, representing the medical profession and by Mr. Ambrose W. Carroll, chairman, Executive Committee, Rhode Island Bar Association, repre-

THROUGH



the Microscope

### Doctor Louis M. Orr is New A.M.A. President

ATLANTIC CITY—Doctor Louis McDonald Orr, fifty-nine, an Orlando, Florida, urologist, was inaugurated Tuesday, June 9 as the 113th president of the American Medical Association.

He succeeds Doctor Gunnar Gundersen, La Crosse, Wisconsin.

As president, Doctor Orr will serve as spokesman for more than 175,000 physicians who are members of the A.M.A.

Doctor Orr had a long and distinguished career with the A.M.A. before he was elected president. He served as vice speaker of the House of Delegates, the A.M.A. policy-making body; as chairman of the federal medical services committee; as an *ex officio* member of the Council on Constitution and By-Laws, and as a member of the Council on Medical Service.

He was born Sept. 27, 1899, in Cumming, Forsyth County, Georgia, while his parents were on a six-week wagon journey to visit his father's only brother.

He entered Emory College, Oxford, Georgia, in 1917, but was drafted into the armed forces in early 1918. He received his B.S. degree in 1922. In 1924, he was graduated from Emory University Medical School, being in the top five of his class.

After serving as a resident in urology and general surgery in the old Lakeside Hospital in Cleveland, Doctor Orr moved to Orlando, where his brother, Clifton, was in business. He opened his practice there in February 1927.

While a surgical house officer at Peter Bent Brigham Hospital, Boston, during a medical school summer vacation, he met Miss Dorothy Brown. They were married Dec. 16, 1927. They have two children, Louis McDonald, Orr, Jr., who is studying medicine at Emory University in Atlanta, and Doris Brown Orr, who is a student at Colby College, New London, New Hampshire.

He has made more than fifty contributions to the scientific literature, and was president of the southeastern section of the American Urological Asso-

ciation in 1943. He is a founding member of the American Board of Urology and has been active in the Florida Medical Committee for Better Government.

### Twenty Per Cent of Adult Population Overweight

Overweight may loom as a major problem for American women, but it is actually a weightier one for American men.

Contrary to popular belief, men in the white population are twice as likely as women to become overweight, according to a recent issue of *PATTERNS OF DISEASE*, published by Parke, Davis & Company for the medical profession. The publication, however, points out that among nonwhite persons, obesity—a condition defined as one in which weight is at least 20% above normal—is more prevalent among women.

In the United States, "one adult in five weighs more than he should," *PATTERNS* states. Twenty per cent of the adult population is 10% or more overweight; 7% is obese.

In determining just who is obese and who is overweight, the height-weight tables often used are not the best guide, *PATTERNS* continues. The scientific method uses specific gravity and skinfold measurements to estimate excess subcutaneous fat.

In dieting, a long-term approach yields best results, the publication reveals. When a person maintains a normal weight for six months to a year following weight reduction, it is likely he will keep his weight down for a long time. "However, as many as 80% of obese persons who embark on a weight reduction program may not complete the regimen for one reason or another."

Among obstacles encountered by would-be dieters, *PATTERNS* reports, are a complex of emotional reactions termed "dieting depression."

"Dieting depression" hampers the progress of up to 54% of those on weight-reduction diets. In a group of 100 dieting obese patients in a nutrition clinic, weakness and nervousness were the most common unpleasant responses, each being reported

*continued on next page*



by about 21% of the patients. Other symptoms included irritability, fatigue and nausea.

Emotional stability plays a major role in successful weight reduction, PATTERNS shows. In a study of 116 adults, none of those reported as reasonably stable had unsuccessful or poor results in weight reduction. The tense, anxious or insecure accounted for 26 cases in the unsuccessful or poor categories, while those with deeper emotional problems accounted for 35 cases in these categories.

### *Excessive Speed Style the Major Cause of Traffic Accidents*

Excessive speed was by far the biggest single cause of traffic accidents that caused more than 2,825,000 injuries and 36,700 deaths on U.S. highways during 1958. The Travelers Insurance Company reported in its latest highway safety booklet.

It was estimated that speed killed and injured nearly 1,000,000 persons in the United States last year, more than 40 per cent of the total.

Cars that did not have the right-of-way were involved in 25.2 per cent of the accidents causing a total of 608,400 injuries during the year. Reckless driving was blamed for 10.4 per cent of the injuries; cutting in for 4.0 per cent and improper signaling for 3.6 per cent.

Crossing at intersections was the chief cause of the 7,700 pedestrians killed and 245,800 injured.

A total of 10.1 per cent, or 27,040 pedestrians were injured while crossing with the signal as compared with 7.4 per cent injured crossing against the signal.

It was reported that 97.1 per cent of the drivers involved in fatal accidents had more than a year of driving experience; that 87.9 per cent of drivers involved in fatal accidents were men; that 87 per cent of the vehicles involved in nonfatal accidents were passenger cars; and that more than 95 per cent of the cars involved were in apparently good condition at the time of the accident.

Dry roads prevailed in 78.3 per cent of the fatal crashes and 70.1 per cent of the nonfatal accidents. The weather was reported as clear in 84.2 per cent of the fatal pileups and 79.5 per cent of the non-fatal mishaps.

### *National Foundation Spells Out a "Beginning" Patient Aid Program*

The National Foundation spelled out in May a "beginning" patient aid program in arthritis and birth defects, thus completing a transition that began last July when the March of Dimes organization announced it would broaden its attack to include these two defects as well as polio.

The organization, originally known as the National Foundation for Infantile Paralysis, already has launched research and professional training attacks on arthritis and birth defects.

Basil O'Connor, president of The National Foundation, said the broadened patient aid program would focus help where it would do the most good and added, "We will, of course, continue to fulfill our basic obligations to polio patients needing assistance." Mr. O'Connor said that continuing polio care needs alone would cost more than \$15,000,000 in March of Dimes funds this year.

Those who will benefit under the new integrated patient aid program are:

Children under 19 with spina bifida, encephalocele or hydrocephalus, three birth defects which may affect the brain or spinal cord;

Children under 19 with rheumatoid arthritis;

Patients with paralytic polio, with emphasis on those severely paralyzed. (Payments for non-paralytic polio will be discontinued.)

"So far as polio is concerned," Mr. O'Connor said, "we are rapidly approaching a time when most new paralytic polio cases must be recognized as preventable and therefore unnecessary. An unprecedented public information program has told the American people what the Salk vaccine can do. It is up to our citizens to use it."

### *Standardized Claims Forms for Health Insurance W'in Acceptance*

The use of Standardized Attending Physician's Statements developed by the Health Insurance Council has been endorsed by insurance companies

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providing 85 per cent of the group accident and health insurance written by the insurance business. In addition, a "steadily increasing number of companies" are adopting the standardized claim forms for individual and family accident and health insurance.

This is disclosed in a progress report just published by the Health Insurance Council on its program of activities conducted during the 12-month period ending March 31, 1959. In booklet form, the report contains excerpts from minutes of the Council standing committees, and from news releases, bulletins, speeches and newsletters on projects at the national, regional and state levels.

The Standardized Attending Physician's Statements—developed in co-operation with the American Medical Association—are designed to reduce paper work for physicians, and at the same time provide insurance companies with the medical information they need to process and pay claims. In this connection, the report further notes that some 136,000 copies of a Council manual published last year titled, *Simplified Claim Forms for Accident and Health Insurance—A Report to the Physician*, have been distributed to members of the medical profession by their societies in thirty-nine states.

#### ***One Third of Annual Crop of New Physicians Receive VA Training***

About one third of the approximately 7,000 new physicians being produced by the United States yearly receive training in Veterans Administration hospitals, Sumner G. Whittier, administrator of Veterans Affairs, reported recently.

Mr. Whittier said medical training is conducted in VA hospitals primarily for its effect in raising the quality of care furnished veteran-patients, and in helping to recruit scarce category personnel for the hospital staffs.

However, the agency's medical education programs also provide training at low cost to the taxpayer and are an important clinical teaching facility for colleges and universities, he said.

The programs are making a major contribution of physicians and other personnel to the trained medical manpower pool of the nation, especially in fields such as psychiatry, clinical psychology, nursing, social work, and the rehabilitation therapies, in which personnel are in critically short supply, Mr. Whittier said.

Dr. Benjamin B. Wells, director of the education service of the VA Department of Medicine and Surgery in Washington, D. C., added that VA hospitals had in training during 1958, in co-operation with colleges and universities throughout the country:

6,000 medical students—about 39 per cent of the nation's third-year medical students and about 33 per cent of its fourth-year medical students.

About 2,500 physicians becoming medical specialists as residents in psychiatry, general surgery, internal medicine, and 16 other fields. This is 11 per cent of the nation's physicians in training as medical specialists during 1958.

70 dental interns and residents, or about 15 per cent of the nation's dental interns and residents during 1958.

#### ***Number of Families Covered by Voluntary Health Insurance Increasing***

The proportion of American families covered by voluntary health insurance is still increasing, Health Information Foundation reported last month. Recent gains in enrollment have been most rapid among a group once considered "uninsurable"—persons 65 or older.

In its monthly statistical bulletin, *PROGRESS IN HEALTH SERVICES*, the Foundation said that 69 per cent of all U.S. families now have at least one member protected by some form of health insurance—an increase of almost 10 per cent since 1953 in the proportion of families covered.

The Foundation published preliminary results of a survey made in co-operation with the National Opinion Research Center of the University of Chicago. A representative cross-section of American families was interviewed at length in 1958 about such questions as what types of medical services

*concluded on page 479*



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## BOOK REVIEWS

*FAT CONSUMPTION AND CORONARY DISEASE: The Evolutionary Answer to this Problem* by T. L. Cleave, M.R.C.P. Philosophical Library, New York, 1958. \$2.50

*DIETARY PREVENTION AND TREATMENT OF HEART DISEASE* by John W. Gofman, M.D., Alex V. Nichols, Ph.D., and E. Virginia Dobbin, Sen. Dietician. G. P. Putnam's Sons, New York, 1958. \$3.95

It has been widely assumed that overconsumption of fats has an important etiologic role in coronary disease. It is caused, according to Cleave, by disregard for the Darwinian theory of the natural law of adaption. This law requires perfect adaption to natural environments and implies that an organism may rely on the instinct of appetite with absolute confidence to tell it what it should or should not eat, but only as long as the instinct is being exercised on natural substances. In civilized countries, *arbitrary meals* and *arbitrary food mixtures* interfere greatly with the natural instinct of appetite, leading to overconsumption of fats for which the individual is not hungry.

Concerning the prevention and arrest of coronary disease, Cleave's suggestion is to eat foods in their natural state (allowing, however, simple cooking) and to "eat these foods in strict proportion to the appetite" and taking food mixtures only if made according to personal tastes. Fried food and many processed foods (such as chocolate, ice cream) which are very rich in fat "are nearly always best avoided altogether."

While Cleave, in his approach, condemns overconsumption of *all* kinds of fats, Gofman and associates stress individualization.

It has been shown that increased lipoprotein blood level increases the incidence of arteriosclerosis and hence the risk of a future heart attack. Lipoproteins may be classified according to their behavior in the ultracentrifuge, into four classes, designated as Sf 0-12, Sf 12-20, Sf 20-100 or Sf 100-400. It has been observed that the risk of coronary artery disease increases if any or all of these lipoproteins are increased in the blood. Thus, individual preventive measures will require, first, the determination of which lipoprotein classes are elevated in a given person, and, secondly, to outline

a diet formula designated to lower those lipoprotein classes most elevated while not increasing any other class appreciably. "Basically, the objective of prevention and treatment of heart disease is to maintain the amount of various important classes of lipoproteins low in the blood stream."

While the Sf 0-12 and Sf 12-20 lipoprotein blood level depends, to an individually different degree, on the intake of animal fats, the Sf 20-100 and Sf 100-400 lipoprotein blood levels depend mostly on the carbohydrate intake.

It has been found that animal fats, hardened vegetable fats and coconut oil raise the level of the Sf 0-12 and 12-20 lipoproteins. When those fats are omitted or replaced in the diet by vegetable oil or fish fat, the Sf 0-12 and 12-20 levels will be lowered. It has also been shown that when overweight is corrected by reducing, all classes of lipoproteins will be reduced if elevated before.

Detailed descriptions of dietary evaluation and recommended diets complete the very readable book of Gofman and associates.

JOHN M. BLEYER, M.D.

*EPILEPSY* by Manfred Sakel. Philosophical Library, N. Y., 1958. \$5.00

This 200-page book on *EPILEPSY* by Manfred Sakel, M.D., published posthumously, is preceded by a rather lengthy introduction by Otto Poetzl which is worth rereading after completion of the book.

The book is divided into two parts, the first dealing with symptoms, etiology and pathogenesis of epilepsy. The current forms of therapy are reviewed with emphasis on physical exercise as a therapeutic measure.

The second part deals with Doctor Sakel's theory of the etiology and treatment of idiopathic epilepsy. This is a result of his study and use of insulin in the treatment of drug addicts and schizophrenic patients. His introduction of Insulin Shock Therapy, in 1934, in the treatment of mental illnesses especially schizophrenia, has been an outstanding contribution to Psychiatry.

From this work, the author postulates an interesting theory of idiopathic epilepsy. "This type of convulsion is the outcome of the fight for supremacy



between the vagus, externally over-stimulated by insulin, and the sympathetic, overcompensated by the internal provocation of the adreno-cortex. . . .

"In idiopathic epilepsy, in order to re-establish the equilibrium upset by irritation between the two opposing ends of the vegetative nervous system, a similar process takes place."

"The disequilibrium between the two ends of the vegetative nervous system and the corollary biochemical dislocation, which on this assumption, is the cause of epileptic symptoms and manifestations."

The author then proceeds to describe his work of thyroid transplants in idiopathic epilepsy. One case described was very successful in controlling the seizures. "The course of events in the histories of these three cases, the donor and the two recipient patients, seems to offer conclusive proof that the over-activation of the thyroid gland may constitute a helpful therapy for idiopathic epilepsy."

The author feels that "the inescapable conclusion is that the hormono-neuro-vegetative system governs all organs; organs responsible for the maintenance of life as well as for the thought processes and abstract psychological concepts."

This emphasis on the hormono-neuro-vegetative system as an etiological factor in many obscure illnesses is stimulating and deserves careful research

and clinical proof.

While this book draws conclusions based on a relatively small volume of research, it provokes one to speculate as to the future possibilities in this area of neuropsychiatry.

The book should be of interest to psychiatrists, as well as the internist and the endocrinologist, who are interested in the vegetative nervous system and its relation to disease.

LAURENCE A. SENSEMAN, M.D.

*VASCULAR SURGERY* by Geza de Takats, W. B. Saunders Co., Phil., 1959. \$17.50

Although it is an axiom that, in the ever-changing world of medicine, it is impossible to produce an up-to-date textbook, Doctor Geza de Takats has just about accomplished this task in spite of an additional handicap, *viz.*, the field of vascular surgery is virtually kaleidoscopic in character at the present time.

The subject matter in a general way parallels that covered by previously published works on peripheral vascular disease, such as the one by Allen, Barker and Hines, with the important difference being that the book in review is the product of a surgeon. Since surgery has made its major advances in recent times only, a peripheral vascular text based on surgical thinking has become a necessity.

*concluded on next page*

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Apart from the shadings of opinion regarding technical matters, such as the choice of materials for prostheses, technique of anastomoses, etc., it is interesting to note that more fundamental differences among the authorities remain to be resolved or, at least, it appears so on the basis of recently published material. While Allen, Barker and Hines feel that thromboangiitis obliterans is an entity distinct and different from arteriosclerosis obliterans and de Takats appears to concur in this opinion, Linton, in a recent review, leads one to doubt whether such a disease does exist.

Doctor de Takats makes the very sensible observation that surgical prudence should always override surgical enthusiasm, and that the total end result is the true criterion of the value of a procedure and not whether it can be accomplished technically.

VASCULAR SURGERY should find its way into all medical libraries as a reference work but into private collections only as the result of a specific need. It is a handsome book (726 pages) of exceptional quality. The legibility of the print and the clarity of the diagrams are unusually good. One notes the abundance of unused space on many pages, at least one figure duplication and several others of limited value. Perhaps this adds unnecessarily to the cost of the book, but it does indicate that nothing has been spared to match its physical qualities with the excellence of its contents.

J. E. CARUOLO, M.D.

*DISEASES OF THE COLON AND ANORECTUM.* Edited by Robert Turell, M.D. Published in two volumes by W. B. Saunders Co., Phil., 1959, \$35.00

The major part of the two volumes is devoted to a detailed presentation of colonic diseases. The second volume, in part, deals with diseases of the anorectum. It is a textbook which borders on being an encyclopedia and has multi-authors. The contributors are all highly authoritative: professors, research workers and master surgeons. Each has written his section in an interesting and individual style.

Considering the number of contributors, there is very little lack of uniformity and difference in clarity of expression. Multiple authorship shows a minimal reduplication of data, and repetitive comments. The text material is well organized and is presented from the viewpoint of diagnosis and currently accepted surgical techniques in treatment. The procedures are profusely illustrated.

Of special interest to the proctologist is the chapter on *Occupational Aspects of Proctologic Disease*. Proctologic diseases of occupational origin have been receiving increasing attention from industrial physicians, proctologists and those who administer

Workmen's Compensation cases. The authors are very thorough in their discussion of the various phases. That "The ultimate decision as to compensability, however, is not a medical but a legal one" is a true statement. Legal opinions which, for some reason, are not documented would prove most educational.

Doctor Turell, in several chapters, demonstrates his inventive genius. He presents several surgical instruments he has developed. The most popular is his biopsy forceps. His anal ring retractor, electrothermic dissector and snare merit consideration.

This text can be recommended without qualification for the surgical resident, for the occasional and general surgeon, and as a reference work in the library of the proctologist.

THADDEUS A. KROLICKI, M.D.

*SURGERY IN WORLD WAR TWO.* Neurosurgery—Volume I. Department of the Army. Office of the Surgeon General, Wash., 1959, \$5.00

This volume deals with the care of head injuries and is chiefly concerned with the European Theater.

Its authors comprise many of the present-day masters of neurosurgery—Matson, Woodhall, Spurling, Walker, Cramer, and others. The first 89 pages are on administration and are of some interest to those men who remember the problem of adapting the scarce individual surgical specialist to the needs of a nation at war. Of more general interest is the rest of the volume which is devoted to the clinical problems. With a considerable amount of technical detail and a minimum of charts, the various contributors recount the problems, methods used, and approximate results in the severe head wounds of war. Detailed methods of operation on the various types of wounds are given.

It is written in a clear, lucid style with excellent illustrations. It is strongly recommended for those interested in head trauma, although it is realized that the lessons learned in war injuries to young men cannot always be applied to the injuries of civilian practice.

THOMAS C. McOSKER, M.D.

#### PROVIDENCE MEDICAL ASSOCIATION

*concluded from page 468*

sending the legal profession. The meeting was then opened for discussion generally.

#### *Adjournment*

The meeting was adjourned at 10:15 P.M.  
Collation was served.  
Attendance was 120.

Respectfully submitted,

MICHAEL DiMAIO, M.D., *Secretary*

## PROVISIONAL VITAL STATISTICS

January — March, 1959

Rhode Island State Department of Health

THIS QUARTERLY REPORT has been compiled from vital records filed with the Division of Vital Statistics during the first three months of 1959. The data for 1958 are given also to obtain an indication of trends. The data are for events that occurred in Rhode Island, regardless of the place of residence. The rates given in this report were computed on an annual basis.

*Births*

During the first three months of 1959, there were 4,744 births recorded, 2.4 per cent greater than last

year's total for the same period. The provisional birth rate for January-March was 21.4 per 1,000 population in 1959, compared with 21.2 in 1958.

*Marriages*

There were 738 marriage certificates filed during the first quarter of 1959, or 5.6 per cent less than for the same period of 1958. The provisional marriage rate per 1,000 population was 3.3 in the first quarter of 1959, as compared with 3.6 for this period of 1958.

TABLE I

Vital Statistics: Rhode Island, January-March, 1958 and 1959

Item	Number		Per Cent Change	Rate		Per Cent Change
	1959	1958		1959	1958	
*Live Births	4,744	4,631	+2.4	21.4	21.2	+0.9
*Marriages	738	782	-5.6	3.3	3.6	-8.3
*Deaths	2,286	2,404	-4.9	10.3	11.0	-6.4
†Infant Deaths	105	94	+11.7	22.1	20.3	+8.9
†Neonatal Deaths	70	66	+6.1	14.8	14.3	+3.5
†Fetal Deaths	62	76	-18.4	13.1	16.4	-20.1

\*Rate per 1,000 population

†Rate per 1,000 live births

*Total Deaths*

The number of deaths recorded during the first three months of 1959 was 2,286. This represents a decrease of 4.9 per cent from 1958. Slightly more than one half of the over-all decrease in deaths was due to a decrease in the number of deaths from influenza and pneumonia. The provisional death rate (10.3 per 1,000 population) was 6.4 per cent lower than the same period last year. The death rate during this season of the year usually runs higher than the annual average.

*Infant Deaths*

Infant mortality for the first three months of

1959 was above that for 1958 for some unexplained reason. The provisional rate was 22.1 per 1,000 live births compared with 20.3 for last year. There was only a slight increase in the neonatal death rate.

*Principal Causes of Death*

The leading causes of death vary only slightly from year to year. Diseases of the heart caused the most deaths, followed by malignant neoplasms. The five principal causes of death on the basis of deaths recorded for the first quarter of 1959 are given below with provisional rates per 100,000 population. The data for the same causes are shown for 1958 also.

TABLE II

Number of Deaths for Five Principal Causes of Death with Rates per 100,000 Population, Rhode Island, January-March, 1958 and 1959

Causes of Death	1959		1958	
	Number	Rate	Number	Rate
Diseases of heart	1,063	478.8	1,055	482.3
Malignant neoplasms	396	178.4	392	179.2
Vascular lesions	250	112.6	242	110.6
Accidents	66	29.7	48	21.9
Diseases of early infancy	58	26.1	58	26.5

concluded on next page



In Table III are shown the provisional numbers of deaths from selected cases with rates for the first

three months of 1958 and 1959.

**TABLE III**  
Provisional Deaths from Selected Causes for First Three Months  
of 1958 and 1959: Rhode Island  
(Excludes fetal deaths. Rates per 100,000 estimated population)

Cause of Death (Seventh Revision of the International Lists, 1955)	1959		1958	
	Number	Rate	Number	Rate
All Causes	2,286	1029.7	2,404	1099.0
Tuberculosis, all forms (001-019)	16	7.2	7	3.2
Syphilis and its sequelae (020-029)	4	1.8	2	0.9
Typhoid fever (040)				
Dysentery, all forms (045-048)	2	0.9		
Scarlet fever and streptococcal sore throat (050, 051)	1	0.5		
Diphtheria (055)				
Whooping cough (056)				
Meningococcal infections (057)			2	0.9
Acute poliomyelitis (080)				
Encephalitis (082)	1	0.5	1	0.5
Measles (085)			3	1.4
Infectious hepatitis (092)	1	0.5		
Malignant neoplasms (140-205)	396	178.4	392	179.2
Diabetes mellitus (260)	37	16.7	51	23.3
Meningitis, except meningococcal and tuberculous (340)	1	0.5	2	0.9
Cardiovascular-renal dis. (330-334, 400-468, 592-594)	1,399	630.2	1,407	643.2
Vascular lesions (330-334)	250	112.6	242	110.6
Rheumatic fever (400-402)			1	0.5
Diseases of heart (410-443)	1,063	478.8	1,055	482.3
Hypertension without mention of heart (444-447)	21	9.5	24	11.0
General arteriosclerosis (450)	25	11.3	45	20.6
Other diseases of circulatory system (451-468)	26	11.7	27	12.3
Chronic and unspecified nephritis (592-594)	14	6.3	13	5.9
Influenza (480-483)	2	0.9	5	2.3
Pneumonia (490-493)	48	21.6	114	52.1
Bronchitis (500-502)	9	4.1	20	9.1
Ulcer of stomach and duodenum (540, 541)	22	9.9	22	10.1
Appendicitis (550-553)	1	0.5	4	1.8
Hernia and intestinal obstruction (560, 561, 570)	15	6.8	14	6.4
Gastritis, enteritis, etc. (543, 571, 572)	5	2.3	9	4.1
Cirrhosis of liver (581)	31	14.0	42	19.2
Acute nephritis and nephrosis (590, 591)			1	0.5
Hyperplasia of prostate (610)	2	0.9	8	3.7
Complications of pregnancy, childbirth, etc.* (640-689)	1	2.1		
Congenital malformations (750-759)	27	12.2	24	11.0
Certain diseases of early infancy (760-776)	58	26.1	58	26.5
Symptoms, senility and ill-defined conditions (780-795)	5	2.3	7	3.2
Accidents (800-962)	66	29.7	48	21.9
Motor-vehicle accidents (810-835)	21	9.5	11	5.0
All other accidents (800-802, 840-962)	45	20.3	37	16.9
Suicide (963, 970-979)	15	6.8	9	4.1
Homicide (964, 980-985)	4	1.8	2	0.9

\*Rate per 10,000 live births

### BOOK REVIEW

*DISEASES OF METABOLISM* by Garfield G. Duncan, M.D. W. B. Saunders Co., Philadelphia and London. 4th Edition—\$18.50

Within the 1,146 pages of this comprehensive text, there is a lucid presentation of factual material that should be a welcome addition to any library. But since many of the basic considerations assume some previous fundamental knowledge of the sciences, undergraduate medical training is a prerequisite for adequate appreciation of each subject.

The first six chapters deal with basic advances in our knowledge of protein, carbohydrate, lipid, and mineral metabolism as well as water balance.

The last ten chapters are concerned with the clinical application of these concepts to the treatment of deficiency states, undernutrition and obesity, diabetes, spontaneous hypoglycemia and the melliturias, Von Gierke's disease, diabetes and insipidus, diseases of the thyroid glands, and diseases of the kidney. In addition a helpful list of references covering all phases of the subject is provided at the end of each chapter, a feature which has greatly increased the value of each contribution. For quick, accurate and ready reference concerning diseases of metabolism, this book should be accorded one's first consideration.

ALBERT F. TETREAU, M.D.

**INTERIM MEETING**  
*of the*  
**RHODE ISLAND MEDICAL SOCIETY**  
*at the*  
**Officers' Club**  
**Quonset Naval Air Station**  
***Wednesday, September 23, at 3:00 P.M.***  
**(Announcement of the program will be  
sent to all members later)**

## THE MEDICAL EDUCATION SITUATION

Hon. Clark W. Thompson, United States Representative from Texas, directed a series of questions to Doctor F. J. L. Blasingame, executive vice president of the American Medical Association, relative to the present supply of doctors in the country, and the prospects for an adequate supply of physicians to meet the needs of our growing population. Doctor Blasingame's reply is reprinted below.

... THE EDITORS

AMERICAN MEDICAL ASSOCIATION,

Chicago, Ill., April 16, 1959.

HON. CLARK W. THOMPSON,  
House Office Building,  
Washington, D. C.

DEAR CONGRESSMAN THOMPSON: Thank you for your recent letter and your interest in medical education.

It is indeed a pleasure to bring you an up-to-date report on the status of medical education in the United States. As you know, I am proud of the accomplishments of our medical schools and have great faith in their ability to train enough physicians to meet the needs of our growing population.

You asked seven important questions about the medical education picture. Let me answer them one by one.

First, has the number of physicians graduated from approved medical schools kept pace with the growth of the Nation's population? Over the long haul, the increase in medical graduates is much greater proportionately than is the increase in the population. From 1920 to 1958, the percentage of increase in medical graduates from approved schools was 125 percent, compared with a 64-percent increase in population. In the past 20 years, the percentage figures are fairly comparable: 32.1-percent increase for medical graduates; 33.4-percent increase for population.

The future, I believe, looks brighter. Each year, for the past 11 years, the number of students enrolled in approved medical schools has increased. This boost in enrollment amounts to 29.6 percent (from 22,739 to 29,473).

Your second question was whether medical schools seek to restrict the number of medical students. Two factors make it necessary for a school

to establish an arbitrary top enrollment figure: facilities and budgetary funds available to operate the school. Each school faculty determines the number of students who can have a sound education with the faculty personnel and the facilities available to the school.

Medical education is a graduate educational experience following the completion of the regular college course, and because of the subject matter covered requires individual and small group instruction. To turn out well-trained, highly-qualified physicians the school requires a large faculty of skilled educators, plus sufficient teaching and research laboratories, hospital beds and clinical patients. The number of students that can be taught must be necessarily restricted to fit the facilities so that the emphasis can be on quality of the graduate rather than on the quantity of students.

Third, you asked: What is the ratio between applicants to medical schools and those accepted? The answer is 1.97 (15,791 applicants for first year medical school to 8,030 places available). This ratio has remained about the same for the past 5 years.

Incidentally, a common confusion that arises in discussing applicants to student ratio is mistaking applications for people (applicants). Each person applies, on the average, to four medical schools. Thus, for the 1957-58 academic year, the 15,791 applicants filed a total of 60,946 applications.

Next, you asked if it is true that only students with an A college academic record are accepted into medical school. That has never been true. About one-sixth of the entering medical students for the whole country have A college records; about two-thirds have B records and about one-sixth have C records.

Your fifth question was: Is the number of medical schools increasing in the United States? In 1944, there were 77 approved medical schools, including eight 2-year schools from which students had to complete their final 2 years of medical education in any of the 69 4-year schools. In 1958, there were 85 approved medical schools. Eighty-one are 4-year schools; only four 2-year schools.

Two other schools are under development. As a step toward still further expansion of medical school facilities, the American Medical Association last year urged "institutions of higher education



where medical education has not been undertaken in the past to give serious consideration to the development of opportunities in the field."

Sixth. Has the American Medical Association anything to do with the number of enrollments in medical schools? Enrollments are strictly determined by each individual medical school. Neither the universities nor their medical schools would permit an intrusion into their academic freedom by a national professional association.

Your final question asked whether I think it is necessary for Federal funds to be provided for medical schools. The medical profession welcomes one-time Federal grants for medical school construction and renovation as well as Federal grants for basic research. The profession has been opposed to continuing Federal aid for operating expenses because of the potentialities therein for Federal control.

I should like to point out that the National Fund for Medical Education, which raises funds from industrial sources, and the American Medical Education Foundation, which raises funds from the medical profession, have made grants in excess of \$10 million to medical education over the past 8 years.

I hope this information will aid you in analyzing bills introduced in the 86th Congress which pertain to the training of physicians. As further background, I am sending along a copy of the most recent annual report prepared by our council on medical education and hospitals, which was published in the *Journal of the American Medical Association*, November 15, 1958. It provides additional data that you might find useful.

I am happy that you wrote me after conferring with our mutual friend, Dr. John Truslow. If I can provide any additional information, please make your wishes known.

Sincerely yours,  
F. J. L. BLASINGAME, M.D.

#### THROUGH THE MICROSCOPE

*concluded from page 471*

they obtain, how they pay for medical care, and what kinds of health insurance they carry.

A full report on the survey is now being prepared. The Foundation bulletin compared highlights of the latest study with a similar one conducted in 1953.

Although coverage under voluntary health insurance increased for all age groups from 1953 to 1958, the Foundation said that the rise was especially notable for persons at the older ages. There was an increase of almost 40 per cent in the proportion of persons 65 or older with health insurance.

According to George Bugbee, Foundation president, recent experience with insuring the aged "offers encouraging proof that at least one group once considered 'uninsurable' can be reached in sizable numbers."

Mr. Bugbee also pointed out that the fastest growing types of voluntary health insurance today provide protection against a broader range of expenses than was common a few years ago.

During the five-year survey period, the proportion of individuals with hospitalization insurance increased from 57 to 65 per cent of the total population, and the proportion with medical-surgical coverage rose from 48 to 61 per cent. Much greater increases were shown during the same period for insurance plans covering not only in-hospital costs but also physicians' fees, drugs, and other out-of-hospital expenses for those few families that incur unusually heavy medical costs.

Despite such increases in coverage, Mr. Bugbee stated, "a still greater proportion of the population could be insured. Current estimates indicate that in five of our most densely populated states—Connecticut, Ohio, New York, Pennsylvania, and Illinois—85 per cent or more of the population is enrolled under some voluntary plan. Current efforts should be aimed at raising the national figure to somewhere near this proportion."



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## DATES YOU SHOULD CHECK

(Mark your calendar now for the dates applicable to you)

*Monday, August 17, and Tuesday, August 18*

*Symposium on the Prevention and Treatment of Athletic Injuries.*

University of Rhode Island.

*Monday, September 14*

Meeting of the Council. Hope Club, Providence.

*Wednesday, September 16, and Thursday, September 17*

Conference on Aging for Representatives of the Medical Societies of New England, at Boston.

*Wednesday, September 23*

*Interim Meeting* of the Rhode Island Medical Society, at the Quonset Naval Air Station,

3:00 P.M.—9:30 P.M.

*Monday, September 28, to Friday, October 2*

College of Surgeons, meeting at Atlantic City, New Jersey.

*Monday, October 5*

Providence Medical Association Meeting. 8:30 P.M.

*Wednesday, October 7*

House of Delegates meeting. Rhode Island Medical Society. 8:00 P.M.

*Wednesday, October 14*

Doctor Isaac Gerber Oration. Miriam Hospital, 8:30 P.M.

*Friday, October 16, and Saturday, October 17*

New England Surgical Society, at Wentworth-by-the-Sea, New Hampshire.

*Saturday, October 17*

Dance. Woman's Auxiliary to Rhode Island Medical Society, Metacomet Country Club.

*Friday, October 23, and Saturday, October 24*

College of Physicians. Northeast and Eastern Canada Regional Meeting, at Providence (Sheraton-Biltmore Hotel).

*Friday, October 30 and Saturday, October 31*

New England Regional meeting, Medical Librarians, at Providence.

*Monday, November 2*

Providence Medical Association meeting. 8:30 P.M.

*Tuesday, November 3, to Thursday, November 5*

New England Postgraduate Assembly. To be held at Boston.

*Wednesday, November 11*

Armistice Day.

*Wednesday, November 18*

Kenney Clinic Day. Pawtucket Memorial Hospital.

*Monday, December 7*

Providence Medical Association meeting. 8:30 P.M.

*Tuesday, December 8, to Friday, December 11*

A.M.A. Clinical Session, at Dallas, Texas.

*Monday, January 4, 1960*

Annual meeting. Providence Medical Association. 8:30 P.M.



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# RHODE ISLAND



AUGUST, 1959

## Medical Journal

Interim Meeting

R. I. Medical Society

Wednesday, September 23

Quonset Naval Air Station

— see page 488

THE N.Y. ACADEMY  
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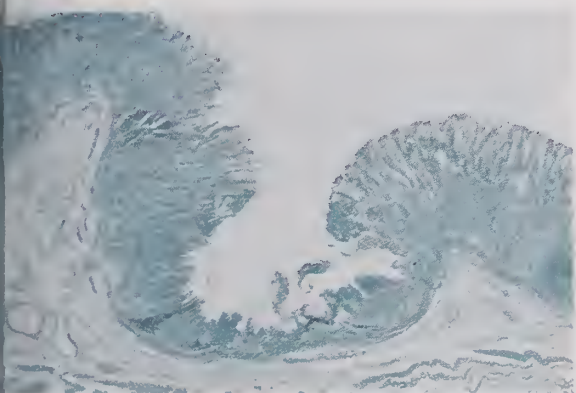
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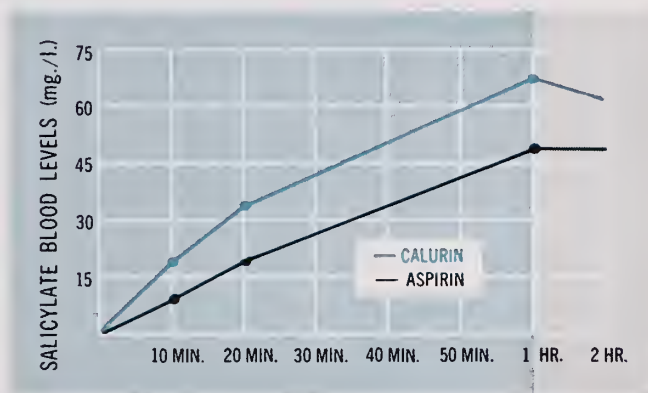
Calurin crystals in solution one min-  
ute after being mixed into water.

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TABLET SOLUBLE CALCIUM-ACETYLSALICYLATE-CARBAMIDE



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- 3 Sodium-free — for safer long-term therapy.
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**Dose:** Each tablet of Calurin is equivalent to 300 mg. (5 gr.) acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times

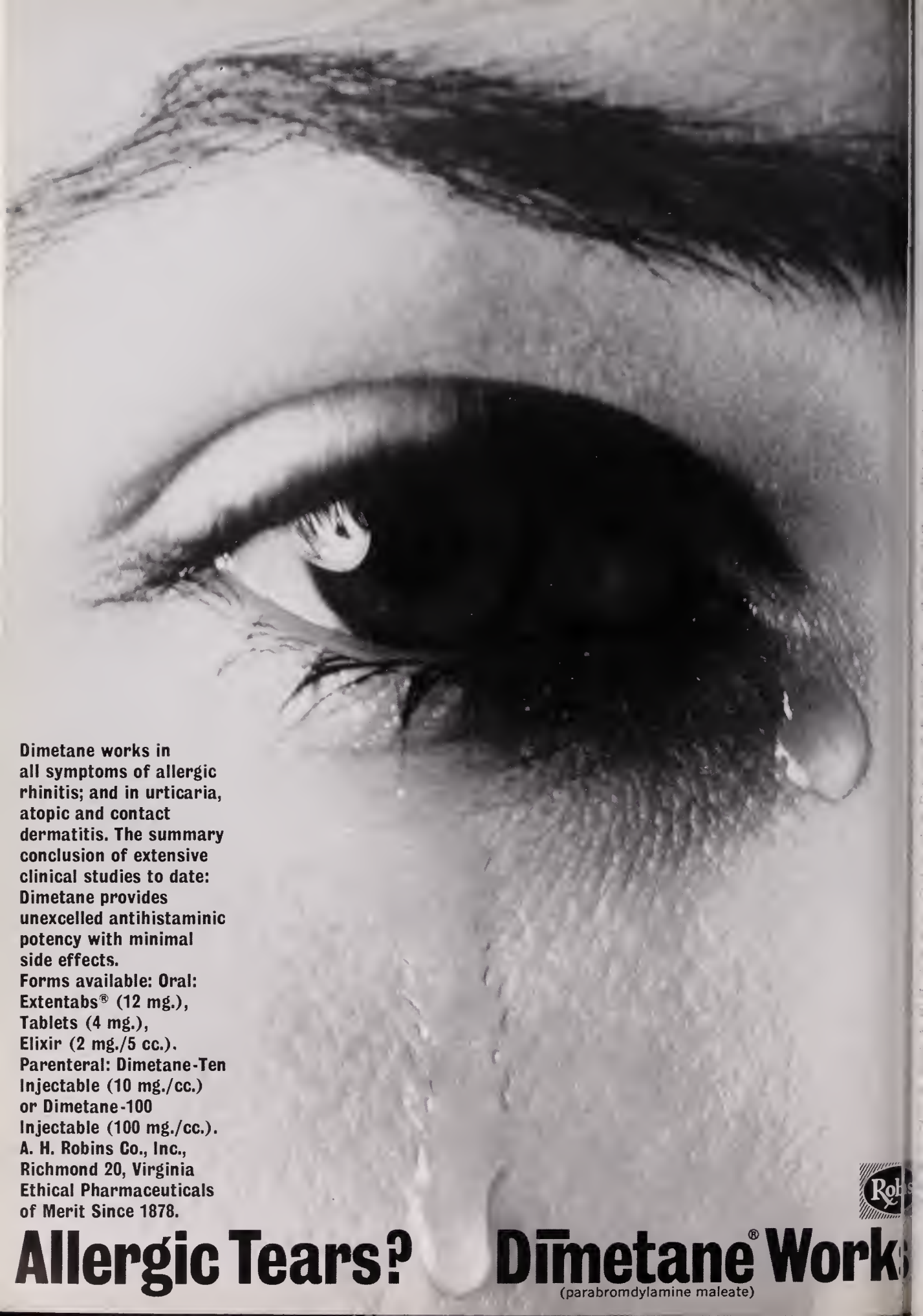
daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

**REFERENCES:** 1. Waterson, A. P.: Aspirin and gastric haemorrhage, *Brit. M. J.* 2:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic observation of the effect of aspirin and certain other substances on the stomach, *Lancet* 2:1222, 1938. 3. Editorial Comments: The effect of salicylic acid (aspirin) on the gastric mucosa, *Canad. M. A. J.* 80:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, *Brit. M. J.* 2:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, *Lancet* 1:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, *Gastroenterology* 35, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, *New Eng. J. M.* 258:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, *New Eng. J. M.* 258:219, 1958. 10. Editorial: Aspirin plain and buffered, *Brit. M. J.* 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium salicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

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## BOOK REVIEW

*THE NEUROSES AND THEIR TREATMENT.* Edited by Edward Podolsky, M.D., F.A.P.A., F.A.P.M. Philosophical Library, N.Y., 1958. \$10.00

In this book Doctor Podolsky has surveyed some forty representative papers concerned with the management of all phases of the neuroses with every treatment from routine psychotherapy to electroshock. He evaluates the newer psychopharmacological aids and, finally, the surgical lobotomies.

This text very ingeniously spans the neuroses and their therapies from infancy and childhood to senility. It opens with an intriguing discussion of the anxieties in infancy, particularly in the first year of life, and terminates with a critical reappraisal of the techniques of Abreaction-Catharsis.

Of psychotherapy in the preverbal stage the author of the paper, Doctor René A. Spitz, observes "that this has to consist in an environmental manipulation, both in regard to love objects and inanimate objects. The needs of the child are simple and an intelligent observation of the child's environment will readily disclose which of these needs is unsatisfied. For its satisfaction no elaborate measures, but only those of the simplest type, need be taken." Clinical features of hysteria in children are discussed by Eli Robins and Patricia O'Neal. In this paper the authors identify and discuss the various criteria to be utilized in making a diagnosis of childhood hysteria. The clinical picture includes the following: a) many symptoms; b) long duration of symptoms; c) presence of the classical pseudo-neurologic symptoms of hysteria and/or abdominal pain and vomiting; d) presence of nervousness or the so-called somatic symptoms of anxiety—palpitation, breathing difficulty, paresthesias, dizziness, fatigue and weak feelings. The use of these criteria seems to help the physician to make the correct diagnosis. Specific cases of hysteria in childhood are described by Marynia F. Farnham, and the psychoanalysis of a case of "Grand Hysteria of Charcot" in a girl of fifteen is presented by Lydia G. Dawes. The pharmacological approach to the treatment of hyperkinetic emotionally disturbed children with prolonged administration of Chlorpromazine is summarized by Dr. Herbert Freed and Charles A. Peifer, B.S., who conclude that "perhaps for the

first time, we have a drug which dampens the primitive fight-flight responses and that we seem to have entered the era where drug therapy and psychotherapy are complementary and can be combined to change the personality most effectively." Dr. J. Bayart discusses the use of Atarax (Hydroxyzine) in the treatment of nervous conditions during childhood and notes its remarkable effects in two well-defined indications: nervous tics and unbalanced, nervous children.

The text, in a series of papers written by various authors, progresses from the neuroses of childhood to those of adult life. Dr. George Frumkes, in a psychoanalytic vein, reviews the development of the sense of reality, *i.e.*, the clear recognition of the difference between the ego and the environment, and gives criteria for evaluating impairment in its development. He further describes the manner in which magical thinking persists in psychopathology, particularly in neurotic symptoms and psychoanalytic resistances. Dr. David C. Wilson writes of the neuroses of everyday living and suggests that to understand the reactions of everyday life one must not look upon them as mass movements, but as examples of individual behavior in response to culture pressures. Only then can the psychiatrist remain in his field of reference, that of treating the personality as a whole. An interesting study of occupational neuroses by Dr. John W. Bick, Jr., concludes with the well-known fact that there is an alarming tendency for individuals to seek financial gain because of an alleged neurosis resulting from industrial accidents. He also cautions against encouraging the patient's neurotic hostility toward his employer or the employer's representative. Drs. Siegfried Fischer and Montague Ullman elaborate in psychoanalytic terms on the instinct of self-preservation and on neurosis and the factors involved in the genesis and resolution of neurotic detachment. The meaning of anxiety is developed by the editor, Dr. Edward Podolsky, who concludes that "the human being exists as a mortal: he is the only being who knows, who can know, that he is mortal. It is this inexorable limit, mortality, finitude and death which determines and characterizes man. It is this awareness of his mortality and uncertainty of the future, the constant threats to his career as a human being that is the source of all

*concluded on next page*



anxieties."

From these psychoanalytic treatises, this textbook goes on to a consideration of the physiologic components of the neuroses; then on to trauma and symptom formation through organ neuroses. Chronic anxiety symptomatology, experimental stress, and HCL Secretion are described by George F. Mahl, Ph.D., and Eugene B. Brody, M.D. In a paper by Dr. Frank C. Metzger, titled *Allergy and Psychoneuroses*, he concludes that "the clinical picture presented by the allergic individual is clouded by psychoneurotic manifestations in a great number of patients. Many allergic seizures which can not be explained on a basis of increased exposure to allergens can be explained on the basis of a complicating emotional experience."

There are chapters in this compilation of papers which deal with the following subjects, *i.e.*, Compulsion Neurosis with Cachexia (Anorexia Nervosa) by Dr. Franklin S. Du Bois; Diagnosis and Treatment of the Phobic Reaction by Dr. Walter I. Tucker; and The Separation Reaction in Psychosomatic Disease and Neurosis by Dr. Henry H. Brewster. The emotional problems of the middle-aged man are also discussed. Drs. Otto Billig and Robert Adams conclude that the emotional problems of the middle-aged man result either in anxiety or in depressive reactions and that his own unresolved Oedipal conflicts make him vulnerable to his role as father. In addition a particular type of anxiety reaction in the post-partum state is presented by Murray DeArmond and discussed in terms of alterations of the body image.

Treatment aspects are considered. The treatment of emotional and behavior disorders in the aging with the addition of Chlorpromazine to the therapeutic regimen is described by Dr. Benjamin Pollack. At the Rochester Jewish Home and Infirmary the use of Chlorpromazine produced a rapid and salutary change in the atmosphere of the Home. The patients began to eat and sleep better; were calm, agreeable, and sociable; and with associated rehabilitative measures, began to take an interest in their environment and in life itself. There is some degree of danger in the use of Chlorpromazine in the aged, *i.e.*, hypotensive reactions, jaundice, dermatitis and Parkinsonism. The process of recovery from severe trauma is interestingly elaborated by Dr. Harley C. Shands. The author and his associates are impressed with the manner in which, after the imposition of intolerable stresses, the resultant strains point up the basic similarity of human patterns in personality disintegration and in the restitution which follows. In a paper concerned with the problem of reassurance as a valid psychotherapeutic technique, Dr. Paul Chodoff suggests that like any other potent method it has its dangers and limitations. Of special importance is the need for the person doing the reassuring to be aware, to

the best of his ability, of his own feelings and motivations and to understand the nature of the relationship between the patient and himself. Dr. Robert Arnot discusses "The Place of Sedatives in the Treatment of Psychoneurotics." In this treatise psychoneuroses are considered as psychophysiologic tension states. Treatment consists of a combination of physical and psychological methods, and general principles for the use of sedatives are given. Drs. Henry H. W. Miles, Jacob E. Fine-singer and Edna L. Barrabee, M.S., evaluate psychotherapy in a follow-up study of sixty-two cases of anxiety neurosis. This study emphasizes the great difficulty in critically appraising the data in terms of accuracy and reliability. However, when the data was evaluated by explicit criteria, twenty-three per cent of the group were found to be markedly improved; thirty-five per cent were definitely better; and forty-two per cent were considered essentially unchanged. There was a close correlation between the evaluations of the authors and the patients' own self-evaluation. Dr. L. J. Meduna reviews the carbon dioxide treatment and its mode of action in the treatment of human neuroses. On the clinical level he observed four different modes of beneficial reactions: 1) simple decreasing and disappearance of the symptoms; 2) direct abreaction of pathogenic emotions; 3) indirect abreaction, and 4) spontaneous analysis and reintegration.

"The Grantham Lobotomy for the Relief of Neurotic Suffering" by Dr. Frank J. Ayd, Jr.; "The Treatment of Anxiety States with Meprobamate (Miltown)" by Dr. Walter A. Osinski; and "Abreaction-Catharsis" by Dr. Harold Palmer constitute the last chapters in this imposing and illuminating compilation. The Grantham Lobotomy implies minimal damage to the cortex which substantially reduces the hazard of post-operative personality changes and convulsions. The recovery period is rapid, and lengthy hospitalization with special nursing care is often unnecessary. The paper indicates that the Grantham Lobotomy is a tremendous step forward in the treatment of neurotic suffering. Dr. Osinski states that meprobamate is as effective as other tranquilizers. It even seems to be safer and better tolerated than some and has the added advantage of not affecting the autonomic functions of the body. Abreaction therapy, according to Dr. Harold Palmer, also has an appropriate place in the treatment of any anxiety state. The author is doubtful whether abreaction can profitably be used on more than one or two occasions.

On the whole, this comprehensive survey is an informative and interesting addition to recent psychiatric literature. I recommend it to the attention of students and practitioners alike.

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## INTERIM MEETING

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Wednesday, September 23, 1959, at 3:30 P.M.

---

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"UNILATERAL RENAL DISEASE WITH HYPERTENSION"—A Case Study

LT. RALPH L. NACHMAN, MC, USNR  
United States Naval Hospital, Newport, Rhode Island

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CAPT. GEORGE L. CALVY, MC, USN  
Commanding Officer, Naval Medical Field Research Laboratory, Camp LeJeune, North Carolina. Recipient of the Edward Rhodes Stitt Award, 1958 (antibiotic medicine)

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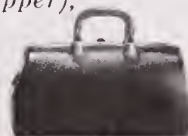
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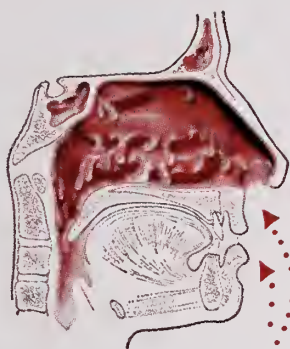
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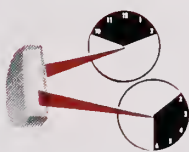
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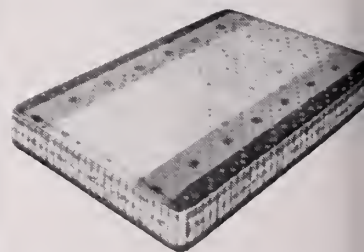
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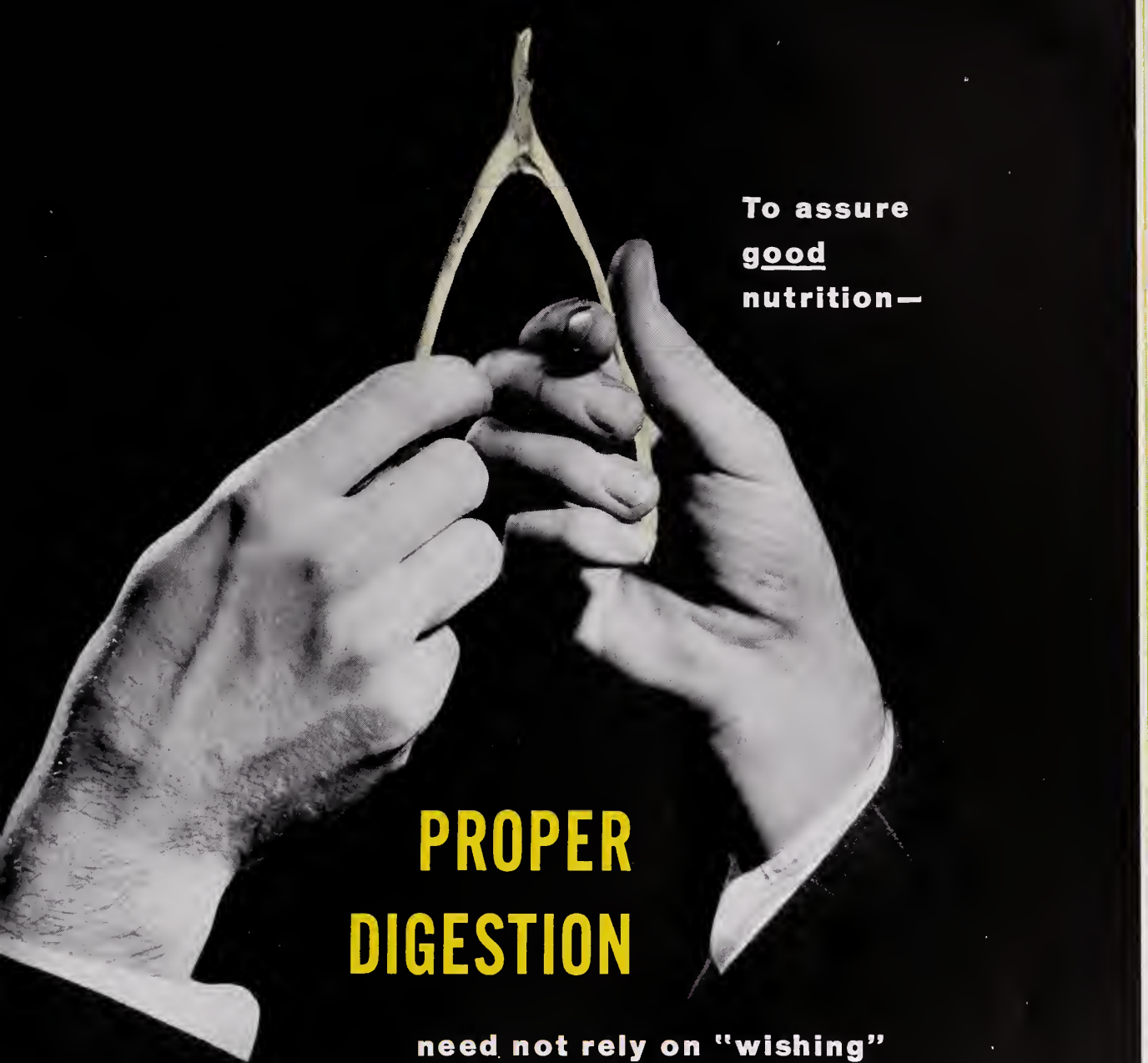
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## *The 76th Caleb Fiske Prize Essay—*

### BRONCHOGENIC CARCINOMA — PREDISPOSING CAUSES\*

ALTON OCHSNER, M.D.

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CANCER OF THE LUNG is increasing more than any other cancer in the body in men and is the most frequent visceral cancer at the present time. In 1920, cancer of the lung represented 1.1 per cent of all cancers in the United States; in 1930, 2.2 per cent of all cancers, and at the present time, 10 per cent of all cancers. Because it is increasing rapidly, it is my belief that unless something is done to prevent it, approximately twenty-five years hence cancer of the lung will represent 30 per cent of all cancers. This is approximately the condition that exists in England today, where in 1931 it represented 5 per cent and in 1952, 26 per cent of all cancer deaths. Also in England, in 1950,<sup>9</sup> 10 per cent of all the deaths in men between the ages of forty-five and fifty-five (the most productive years of a man's life) were the result of cancer of the lung. There was a thirty-eight-fold increase in the incidence of cancer of the lung in England<sup>24</sup> from 1920 to 1954. In Holland,<sup>19</sup> from 1924 to 1951 lung cancer increased tenfold in women and twenty-four fold in men. In Switzerland,<sup>14</sup> it increased thirty-two fold from 1900 to 1952, during which time the population increased only 1.4 fold, all deaths 0.8 fold, and all cancers, 1.9 fold. In Finland,<sup>18</sup> lung cancer increased approximately 7 per cent each year from 1936 to 1943, after which the annual increase became approximately 13 per cent. The per capita consumption of tobacco has been higher in Finland since the early 1900's than in any other European country. In Austria, lung cancer represented 1.6 per cent of all cancers in 1920, 2.2 per cent in 1930, and 10 per cent in 1956. Clemmesen<sup>2a</sup> stated that in Copenhagen in the period 1985-1990 lung cancer deaths in men will equal those from all

cancers in 1950. He<sup>5</sup> also referred to the incidence of bronchogenic carcinoma as being *pandemic* and warned that unless young persons are prevented from acquiring smoking habits, a major catastrophe in medical history will be unavoidable. The Norwegian government is so convinced of the causal relationship between smoking and lung cancer that they forbid the sale of tobacco to minors, and 0.1 per cent of the government's tobacco revenue is allocated for research on the deleterious effects of tobacco.<sup>2</sup> In Massachusetts<sup>29</sup> cancer of the lung has now become the most frequent cancer and even supersedes cancer of the breast. Levin<sup>22</sup> reported that in New York State from 1931 to 1950, cancer of the lung in males increased 385 per cent, whereas cancer in all other sites increased only 2 per cent. In females during the same period of time, there was an increase of 68 per cent in cancer of the lung and a decrease of 15 per cent in cancer in all other sites.

Many authorities maintain that cancer of the lung has not increased but is being recognized at the present time, whereas previously it was misdiagnosed as some other lesion. We are convinced that this is not a correct assumption and that cancer of the lung is in reality a new disease. Clemmesen,<sup>5</sup> who is an eminent pathologist in Denmark and who has been extremely interested in the epidemiology of cancer for a number of years, is convinced from his study of the Cancer Registry in Denmark that the increased incidence of cancer of the lung is real and not relative. In discussing the remarkable increase in the incidence of cancer of the lung, Clemmesen stated: "It seems impossible to escape the conclusion that from the studies reported we are now facing the beginning of one of the major catastrophes in medical history, a mortal disease which demands decades for its development and probably as lengthy efforts for its prevention." Another reason I am convinced that the incidence in bronchogenic cancer is actual and not relative because of better diagnosis is that in the Germanic countries, such as Germany, Denmark, and Holland, where, since the time of Virchow, autopsies

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have been done almost routinely for the past one hundred years, the incidence of bronchogenic cancer has increased as it has here. It is inconceivable that the carefully trained German pathologist would have missed bronchogenic cancer if he saw it at autopsy twenty-five years ago. Wegelin<sup>22</sup> reported a progressive increase in the incidence of lung cancer, as determined at autopsy in the Berne Pathological Institute, from 2.5 per 100,000 autopsies in the period 1900-1904 to 14.2 in the period 1935-1939. Also Matz<sup>23</sup> found the incidence of bronchogenic carcinoma to all carcinoma as determined by autopsy in the Veterans Bureau Hospitals in the United States increased from 6.4 per cent for the period 1927 to 1931 to 15.8 per cent for 1932-1937 and to 23.4 per cent for the year 1937. O'Neal and his co-workers<sup>26</sup> found that the incidence at Barnes Hospital in St. Louis increased from 1.1 per cent of all autopsies in 1910-1919 to 4.2 per cent in 1930-1939 and to 7.8 per cent in 1945-1954.

### *Lung Cancer Behavior Different*

Whereas all cancers increase generally with advancing age and are usually considered degenerative diseases, cancer of the lung behaves differently. The incidence of all other cancers increases with advancing age, that is, of all the persons ninety years of age, a greater percentage will have cancer than those eighty, of those eighty years of age, a greater percentage will have cancer than those seventy, and so on. The one exception is cancer of the lung which increases very sharply to reach a peak age of approximately fifty-five, following which, with advancing age, there is a decrease in the incidence. Cancer of the lung is the only form of cancer which behaves in this way and which does not increase with advancing age. This lack of conformity in bronchogenic cancer is that persons who have subjected their heart and blood vessels to the deleterious effects of tobacco over a number of years are likely to develop fatal coronary artery disease and not live long enough to develop cancer of the lung.

For at least twenty years, I have been convinced that there is a causal relationship between smoking and cancer of the lung, although originally my reasons were very tenuous and were based upon a parallelism between the incidence of cancer of the lung and the consumption of cigarettes and also because cancer of the lung was extremely unusual in the nonsmoker. Many others have also become convinced of the causal relationship. Clemmesen<sup>5</sup> believes that the tremendous increase in the incidence of cancer of the lung in Denmark is due to cigarette smoking. Delarue,<sup>6</sup> in France, is equally convinced of the causal relationship between smoking and cancer. He stated: "The evidence to support this thesis is sufficiently definite that cigarette

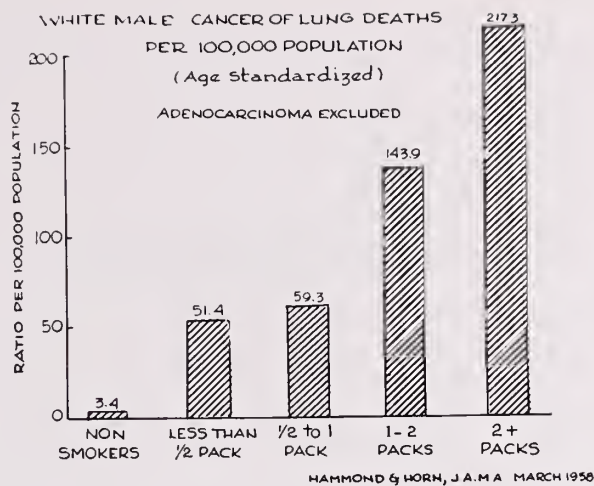
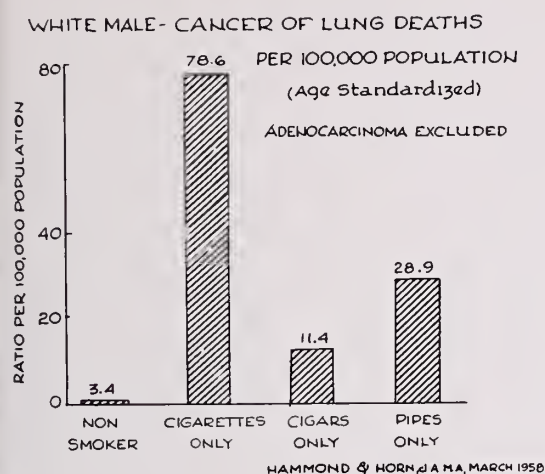
manufacturers now have a moral obligation to attempt to prove or disprove its validity and to eradicate any carcinogenic agent from their product when and if it is isolated." Doll and Hill<sup>10</sup> in England stated: "At about the age of forty-five, the risk of developing the disease (bronchogenic cancer) increases in simple proportion to the amount smoked, and it is approximately fifty times as great among those who smoked twenty-five or more cigarettes a day as among nonsmokers." Levin<sup>22</sup> stated: "The weight of evidence, therefore, indicates the relationship between cigarette smoking and lung cancer is causal and not merely an association." He further stated: "From the practical standpoint, we believe there is already enough evidence incriminating cigarette smoking to justify advising the public that the available evidence is consistent with the view that cigarette smoking is one of the causative factors in lung cancer and that stopping cigarette smoking may, therefore, be a means of lowering the incidence of lung cancer."

Until the middle 1930's, the incidence of bronchogenic cancer in both sexes was practically the same. At about this time, however, there was a tremendous increase in the incidence of the disease in males, which, undoubtedly, was due to the fact that during World War I (1914-1918) men began smoking cigarettes excessively and the length of time between 1914 and the middle 1930's was sufficiently long for the carcinogenic effect of smoking to become evident. There was some increase in the incidence of cancer of the lung in women during this same period of time, but much less than in men because even today men use cigarettes much more than women. According to the United States Health Report, in 1956, 67% of the nonsmokers in the United States were women and only 33% were men.

Many persons are unwilling to admit that there is a causal relationship between smoking and lung cancer, but in my experience these individuals are, without exception, either in the employ of the tobacco industry or are addicted to cigarette smoking themselves. In both instances, it would be difficult for the individual to admit a causal relationship.

### *British Experience*

It has often been stated that the reason the incidence of cancer of the lung is higher in London than in the United States is because of the smog in London. This might be true were it not for the fact that in Denmark, immediately across the English Channel, where the incidence of cancer of the lung and the per capita consumption of cigarettes are practically identical with that in London, there is no smog. Also, in Pittsburgh, which until relatively recently had had smog for approximately one hundred years, cancer of the lung is less frequent than in New Orleans. Those who would have



FIGURES 1 and 2

us believe that the increased incidence of cancer of the lung is due to smog fail to explain why a similar increase has not occurred in women as in men, because certainly women breathe the same air as men. A study by Stocks and Campbell<sup>30</sup> suggests, however, that air contamination may act as an additive factor to smoking in causing lung cancer.

It is frequently stated that because we in the United States smoke more than the British and because the incidence of lung cancer is less here than in England, there can be no causal relationship between smoking and cancer. Although it is true that the incidence of cancer of the lung is higher in England than it is in the United States and also that Americans smoke more than the British, this is only a half-truth because, although we consume more cigarettes than the British, we have done so for approximately only nine years. Prior to that time, the British smoked much more than we, and they are now paying the price for their very heavy smoking for the past twenty-five years. It is frightening to envision what will happen to us in the next fifteen or twenty years when our smoking habits catch up with us.

For many years it has been obvious to thoracic surgeons that the incidence of heavy cigarette smokers among patients with carcinoma of the lung is much higher than that among the average general hospital population. Wynder and Graham,<sup>33, 33a</sup> from a study of their patients with lung cancer, stated that excessive and prolonged smoking was an important factor in the production of bronchogenic cancer. Watson<sup>31</sup> found that 37 per cent of lung cancer patients in the Memorial Hospital and only 19 per cent without cancer of the lung were heavy smokers. Schrek and his associates<sup>28</sup> stated: "The positive correlation between the incidence of cigarette smoking and the incidence of cancer of the respiratory tract appears to be statistically and

biologically significant. There is strong circumstantial evidence that cigarette smoking was an etiologic factor in cancer of the respiratory tract."

#### Statistical Studies Offer Evidence

Many persons object to drawing conclusions on such retrospective statistics, and because of such objections, several years ago the American Cancer Society undertook a prospective statistical study to determine the incidence of bronchogenic cancer among smokers as contrasted with that among nonsmokers.<sup>10a</sup> This consisted of an annual interview of approximately two hundred thousand men between the ages of fifty and seventy concerning their smoking habits. The study was continued for five years. The final analysis of this study showed that the death rates from lung cancer were dependent upon the smoking habits of the individuals and varied according to the amount smoked. The death rate in heavy cigarette smokers was 800 per cent higher than in nonsmokers! (Fig. 3.) The study further showed that the risk of bronchogenic cancer decreased if one discontinued smoking and that the longer the time elapsed since discontinuance, the less the risk, but that risk was greater in the heavy smokers than in those who smoked moderately (Figure 4).

A completely independent, but similar prospective statistical study, was made by the Veterans Administration and reported to the Seventh International Cancer Congress by Dorn.<sup>11</sup> This study also showed that the incidence of lung cancer varied according to smoking habits and that the more cigarettes smoked, the greater the incidence of the disease. Doll and Hill,<sup>10c</sup> in a similar study of the physicians in England, obtained comparable results. The standardized annual death rates from the lung cancer per one hundred thousand men thirty-five years of age and older were nonsmokers, 7;

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PER CENT INCREASE IN DEATHS IN  
HEAVY CIGARETTE SMOKERS OVER NON-SMOKERS

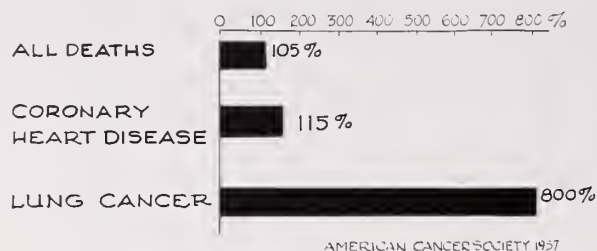


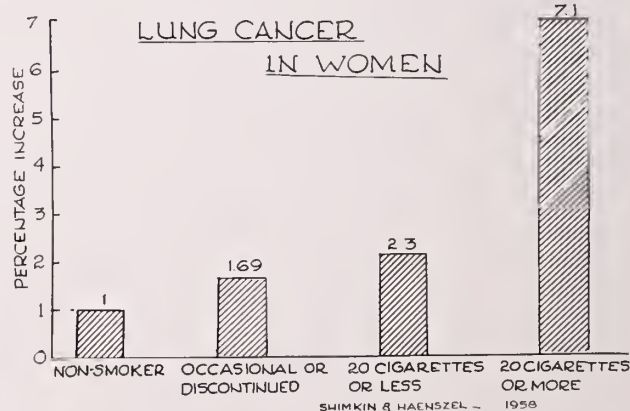
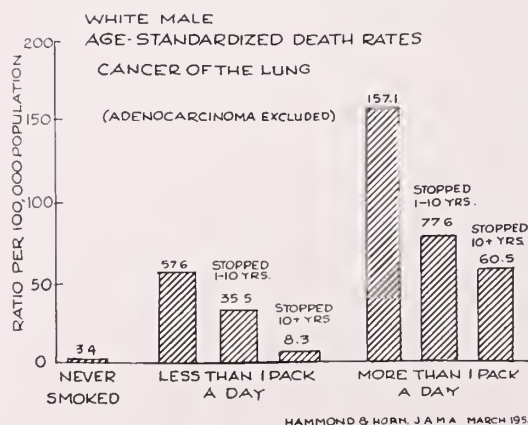
FIGURE 3

pipe smokers, 38; pipe and cigarette smokers, 68, and cigarette smokers, 125. They also found that the incidence varied with the amount smoked as follows: nonsmokers, 7; smokers of one to fourteen cigarettes daily, 47; fifteen to twenty-four cigarettes daily, 87, and twenty-five or more cigarettes daily, 166. The study further showed that the incidence decreased if smoking was discontinued and the longer the time elapsed, the greater the decrease. In an editorial in the *BRITISH MEDICAL JOURNAL*,<sup>12</sup> commenting on the Doll and Hill study, the following statement was made: "The weight of evidence of smoking as a causal connection with lung cancer, already sufficient to convince an unbiased observer, has been greatly increased by the latest reports of Doll and Hill. The new evidence makes it far more than ever imperative that the public is repeatedly informed of the possible dangers of health and life from smoking cigarettes." The above mentioned statistical studies were on men, but in women there is also a relationship between the amount smoked and the incidence of lung cancer as demonstrated by Haenszel and Shimkin's study<sup>17</sup> (Figure 5).

For many years, it was stated that there could be no causal relationship between smoking and cancer of the lung, because precancerous lesions were not found in the tracheobronchial tree. Several years ago, Costilow,<sup>7</sup> while a senior medical student at Tulane University, made observations on men coming to autopsy and showed that the changes in

the bronchial mucosa varied according to the smoking habits, that older persons who do not smoke have a normal appearing mucous membrane, that moderate smokers have metaplastic changes in the bronchial mucosa, and that heavy smokers have definite precancerous changes. These preliminary observations have been corroborated and substantiated much more conclusively by Auerbach and his associates,<sup>3</sup> and Chang,<sup>4</sup> who demonstrated that changes occur in the bronchial mucosa, ranging from hyperplasia, metaplasia, precancerous lesions, early invasive cancer, to extensive cancer, depending upon the amount smoked.

Doctor Evarts Graham, who did more to advance the rational treatment of bronchogenic cancer than anyone else in the world, originally was of the opinion that there was no causal relationship between smoking and cancer of the lung. He believed that the parallelism between the consumption of cigarettes and the incidence of cancer of the lung was purely coincidental. He later became convinced, however, that there was a causal relationship and the experimental investigations by him, Wynder, and Croninger<sup>23, 23a</sup> showed without any question or doubt that there is a cancer-producing agent in the smoke from cigarettes. They used a robot machine which smoked sixty-four cigarettes at a time in the same manner that human beings smoke, in that every sixty seconds a drag of two seconds was taken. The cigarette smoke was collected and cooled. A tarred residue was obtained, which, when added to a solvent, was applied to the skin of animals three times a week. At the end of two years, 44 per cent of the animals developed a cancer at the site of the application of the tar and the solvent. This cancer was identical with that in human beings in that it metastasized and killed the animals. In a control group of animals to which only the solvent was applied three times a week in an exactly similar manner as in the experimental group, not one animal developed, at the end of two years, either a



FIGURES 4 and 5



benign or a malignant tumor at the site of the application of the solvent. In 1943, Roffo<sup>27</sup> produced cancer in animals by applying tobacco tar to the skin of the animals. Cooper and Lindsey<sup>6</sup> found in the smoke obtained from cigarettes a number of polycyclic hydrocarbons, particularly 3:4 benzpyrene and 1:12 benzoperlene, both of which are carcinogenic. Similarly, Latarjet and his co-workers<sup>20</sup> found 3:4 benzpyrene in the smoke from cigarettes and showed that this carcinogenic agent was present both in the cigarette paper and the tobacco. Essenberg and his associates<sup>13</sup> were able to produce bronchogenic neoplasms by subjecting animals to cigarette smoke. Leuchtenberger and associates<sup>21</sup> showed that in mice subjected to cigarette smoke there were changes in the bronchi that varied from bronchitis with mild proliferative epithelial changes to those with atypical basal hyperplasia, squamous cell hyperplasia, and even carcinoma in situ.

Many persons state that one cannot compare animal cancer with human cancer and that for this reason Wynder and Graham's work is of no value. No attempt was made to compare animal cancer with human cancer. The work simply proved without any question or doubt that there is a cancer-producing agent in smoke from cigarettes. It is well known that cancer of the lung is increasing more than any other cancer and that it parallels the consumption of cigarettes. The annual per capita consumption of cigarettes in the United States in all persons fifteen years of age and older has increased from 16 in 1880 to 3,556 in 1953! However, it did decrease in 1956 to 3,195. These facts together with the proved fact that there is a carcinogen in the smoke from cigarettes leads to the only logical conclusion: *There is a causal relationship between the two.*

### *Casual Relationships Questioned*

In spite of all this evidence, some persons still will not accept the fact that there is a causal relationship between smoking and cancer. In commenting upon this attitude, Graham<sup>15</sup> remarked: "To satisfy the most obdurate of the diehards, it would be necessary to take the following steps: (1) Secure some human volunteers willing to have a bronchus painted with cigarette tar, perhaps through a bronchial fistula. (2) The experiment must be carried out for at least twenty to twenty-five years. (3) The subjects must spend the whole period in air-conditioned quarters, never leaving for more than an hour or so, in order that there may be no contamination by a polluted atmosphere. (4) At the end of twenty-five years they must submit to an operation or an autopsy to determine the results of the experiment." Clemmesen<sup>7</sup> succinctly stated: "The academic proof of the carcinogenic

quality of tobacco smoke claimed so eagerly for all but academic reasons may, therefore, be produced by removal of the suspected agent from 50 per cent of the agent previously exposed, followed by the disappearance, complete or partial, of the disease from the same 50 per cent." He further stated: "It is true that we have no guarantee of the effects until we know the chemical nature of the carcinogen or further experiments are carried out, but we cannot wait while men are dying by the thousands. Where were the guarantees in combat against the epidemics of the past? Let no one believe that the attitude of the public will remain indifferent to us in our responsibility when in one or two decades extension of the catastrophe will become apparent to everyone."

The fact that there are patients with cancer of the lung who have not been smokers is frequently advanced as proof that smoking has no relationship to cancer. Almost without exception, such an individual has an adenocarcinoma, and the American Cancer Society studies<sup>16, 16a</sup> have shown that there is no relationship between smoking and the incidence of adenocarcinoma. I have been so convinced of the causal relationship between smoking and cancer that, for the past five years, I have contended that an individual who does not smoke, but who has a pulmonary lesion which might be bronchogenic cancer either has adenocarcinoma or does not have a malignant disease. In the five years I have been wrong only twice. There is no other diagnostic criterion which is as nearly so accurate as this one, and I believe the history of smoking is of extreme importance diagnostically.

Approximately two years ago, the American Cancer Society, the American Heart Association, the National Cancer Institute, and the National Heart Institute<sup>1</sup> (the latter two are agencies of the Federal government) appointed a committee of seven scientists to study and evaluate all the available data regarding the effects of smoking on health. These scientists were chosen because of their integrity and ability to analyze critically experimental and clinical investigations. After an intensive study of one year, they concluded: "The sum total of scientific evidence establishes beyond reasonable doubt that cigarette smoking is a causative factor in the rapidly increasing incidence of human epidermoid carcinoma of the lung." No statement could be more definite and conclusive than this. This was the conclusion arrived at by an independent group of eminent scientists appointed by four prominent health organizations, both private and governmental. Their exhaustive and impartial study and analysis of all evidence available make the acceptance of the causal relationship of cigarette smoking to lung cancer virtually mandatory.

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The Medical Research Council of Great Britain,<sup>23</sup> a government agency, recently drew the following conclusions after extensive investigations over a period of five years. "Evidence from many investigations in different countries indicates that a major part of the increase (of lung cancer) is associated with tobacco smoking, particularly in the form of cigarettes. In the opinion of the Council, the most reasonable interpretation of this evidence is that the relationship is one of direct cause and effect. The identification of several carcinogenic substances in tobacco smoke provides a rational basis for such causal relationship." The British government also has posted in all public places large yellow posters with the following inscription:

"To all Smokers! There are now the strongest reasons to believe that smokers—particularly of cigarettes—run a greater risk of lung cancer than nonsmokers. The more cigarettes consumed, the greater the risk."

The fact that an agency of the British government, which receives such enormous income from tobacco taxes, would make this unqualified statement to its people has great significance for us and for the health agencies of our Federal government.

The question is no longer whether bronchogenic cancer is caused by cigarette smoking, but what will be done to remove the carcinogen in tobacco. At present there are no available methods and until such are developed, it behooves all cigarette smokers to refrain from smoking completely and to have a chest roentgenogram every six months so that when precancerous changes in the bronchial mucosa progress so far as to be non-reversible, the resultant malignant lesion can be detected at a time while it is resectable and curable.

#### BIBLIOGRAPHY

- <sup>1</sup>American Cancer Society, American Heart Institute, National Cancer Institute and National Heart Institute: Report of Study Group on Smoking and Health. New York Times, March 23, 1957
- <sup>2</sup>Antitobacco campaign: J.A.M.A. (Foreign Letters) 168:1151-1152 (Oct. 25) 1958
- <sup>3</sup>Auerbach, O.; Petrick, T. G.; Stout, A. P.; Statsinger, A. L.; Muehsam, G. E.; Forman, J. B., and Gere, J. B.: The anatomical approach to the study of smoking and bronchogenic carcinoma. A preliminary report of forty-one cases. *Cancer*, 9:78-83 (Jan.-Feb.) 1956
- <sup>4</sup>Chang, S. G.: Microscopic properties of whole mounts and sections of human bronchial epithelium of smokers and non-smokers. *Cancer*, 10:1246-1262, 1957.
- <sup>5</sup>Clemmesen, J.: Bronchial carcinoma: A pandemic. *Danish M. Bull.*, 1:37-45, 1954
- <sup>5a</sup>Clemmesen, J.: On the endemiology of bronchial carcinoma. *Acta chir. Scandinav.*, 111:238-239, 1956
- <sup>6</sup>Cooper, R. L., and Lindsey, A. J.: 3:4 Benzpyrene and other polycyclic hydrocarbons in cigarette smoke. *Brit. J. Cancer*, 9:304-309, 1955
- <sup>7</sup>Costilow, M.: Cited by Ochsner, A.; Ray, C. J., and Acree, P. W.: Cancer of the lung: A review of experiences with 1457 cases of bronchogenic carcinoma. *Am. Rev. Tuberc.*, 70:763-783 (Nov.) 1954
- <sup>8</sup>Delarue, N. C.: Bronchogenic carcinoma: The present challenge. *S. Clin. North America*, pp. 911-929 (Aug.) 1954
- <sup>9</sup>Doll, R.: Bronchial carcinoma: Incidence and aetiology. *Med. World*, 80:370-391 (April) 1954
- <sup>10</sup>Doll, R., and Hill, A. B.: Smoking and cancer of the lung: Preliminary report. *Brit. M. J.*, 2:739-748 (Sept.) 1950
- <sup>10a</sup>Idem: A study of the aetiology of carcinoma of the lung. *Brit. M. J.*, 2:1271-1286, 1952
- <sup>10b</sup>Idem: The mortality of doctors in relation to their smoking habits: A preliminary report. *Brit. M. J.*, 1:1451-1455, 1954
- <sup>10c</sup>Idem: Lung cancer and other causes of death in relation to smoking: A second report on the mortality of British doctors. *Brit. M. J.*, 2:1071-1081, 1956
- <sup>11</sup>Dorn, H. B.: Tobacco consumption and mortality from cancer and other diseases. Presented before the 7th Int. Cancer Congress, London, July 8, 1958
- <sup>12</sup>Editorial: *Brit. M. J.*, 2:1071-1081 (Nov. 10) 1956
- <sup>13</sup>Essenberg, J. M.; Leavitt, A. M., and Gaffney, E.: A possible carcinogenic agent in cigarettes. *Proc. Am. A. Cancer Research*, 2:14-15, 1955
- <sup>14</sup>Gsell, O.: Tobak und Krebs: Klinische und statische Erhebung, mit besondere. Berücksichtigung der Schweiz. *Oncologia (Basel)* 10:157-186, 1957
- <sup>15</sup>Graham, E. A.: Remarks on the etiology of bronchogenic carcinoma. *Bull. Am. Coll. Surg.*, 40:128-133 (March-April) 1955
- <sup>16</sup>Hammond, E. C., and Horn, D.: The relationship between human smoking habits and death rates. *J.A.M.A.*, 155:1316-1328 (August 7) 1954
- <sup>16a</sup>Hammond, E. C., and Horn, D.: Smoking and death rates. Report on forty-four months of follow-up of 187,787 men. *J.A.M.A.*, 166:1159-1172 and 1294-1308, 1958
- <sup>17</sup>Haenszel, W.; Shimkin, M. B., and Mantel, N.: A retrospective study of lung cancer in women. *J. Nat. Cancer Inst.*, 21:825-842, 1958
- <sup>18</sup>Holsti, L. R., and Ermala, T.: Tupakka ja syöepäe. II Klüninen ja patologinen aineiste. *Duodecim*, 71:1115-1134, 1955
- <sup>19</sup>Korteweg, R.: The fight against lung cancer. *Documenta de Med. Geograph. et Trop.*, 5:168-172 (June) 1953
- <sup>20</sup>Latarjet, R.; Cusin, J.; Hubert-Habart, M.; Muel, B., and Royer, R.: Détection quantitative du 3, 4 benzo-pyrene formé par combustion du papier à cigarettes et du tabac. *Bull. du Cancer*, 43:180-198, 1956
- <sup>21</sup>Leuchtenberger, R., and Doolin, P. F.: A correlated histological, cytological and cytochemical study of the tracheobronchial tree in lungs of mice exposed to cigarette smoke. *Cancer*, 11:490-506, 1958
- <sup>22</sup>Levin, M. L.: Etiology of lung cancer: Present status. *New York State J. Med.*, 54:769-777, 1954
- <sup>22a</sup>Levin, M. L.; Kraus, A. S.; Goldbert, I. D., and Gerhardt, P. R.: Problems in the study of occupation and smoking in relation to lung cancer. *Cancer*, 8:932-936, 1955
- <sup>23</sup>Matz, P. B.: Incidence of primary bronchogenic carcinoma. *J.A.M.A.*, 111:2086-2092 (Dec. 3) 1938
- <sup>24</sup>McKenzie, Alan: The diagnosis of cancer of the lung and stomach. *Brit. M. J.*, 2:204-207 (July 28) 1956
- <sup>25</sup>Medical Research Council of Great Britain: Tobacco smoking and cancer of the lung: The increase in lung cancer. *Brit. M. J.*, 1:1523-1524 (June 29) 1957
- <sup>26</sup>O'Neal, R. M.; Lee, K. T., and Edwards, D. L.: Bronchogenic carcinoma. An evaluation from autopsy data, with special reference to incidence-sex ratio, histologic type, and accuracy of clinical diagnosis. *Cancer*, 10:1031-1036, 1951



## THE SURGICAL APPROACH TO IMPROVEMENT IN HEARING\*

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THE LOSS of hearing is very distressing at any age. It occurs of course in infancy as well as in the elderly and middle ages, and may occur as a result of inheritance, or it may be acquired as a result of conductive or perceptive loss during any age. We are concerned now with the surgical approaches for the correction of these defects whenever possible, hoping to improve the opportunities for better hearing through judicious use of surgery in and about the ear.

As you have heard from Doctor Gammell, the removal of obstructing hypertrophied lymphoid tissue in and about the eustachian tubes has been a fundamental surgical procedure in the correction of some of the catarrhal conditions of deafness, and he has told you of the therapy which involves the application of radium or X ray to accomplish shrinkage of the obstruction. Incision of the drum and aspiration of the contents of the middle ear which is inflamed or fluid-filled is likewise a fundamental approach. We take for granted that in an acute, a subacute and a chronic mastoiditis, surgery is helpful in restoring temporarily suppressed hearing. We will but mention briefly the fenestration operation which was so brilliantly conceived by Julius Lempert, Gunner Holmgren, and Sourdille and which has taken its place in the firmament of progress in surgery. This remains a very useful procedure and will continue to be used for the correction of hearing defects due to otosclerosis. Today, we want to tell you something of the correction of this same disease by a method called Stapes Mobilization.

About five years ago, Doctor Rosen in New York brought about a renaissance of the mobilization of the stapes when its footplate is fixed to the oval window by the disease otosclerosis. This disease occurs in early childhood occasionally, and in the aged fairly often, but most frequently is seen in the twenty, thirty or forty decades. Pathologically, it

occurs as a local excrescence in the oval window, usually at either end of the footplate of the stapes, causing suppression of vibration and thus impairment of hearing. This causes the patients to complain of a confusion of sounds when in groups of people, many of whom may be talking at once; also there is difficulty in hearing in church or the theater and in advanced cases, of course, in ordinary conversation. There is usually a family history of hearing impairment and almost always a history of tinnitus. Sometimes in noisy surroundings, the patient seems to hear better because the people around him are talking louder and carrying their voices more directly to the individual. With the very advanced cases the hearing impairment, as a result of disuse of nerve tissue, presumably causes a diminishing reserve of hearing within the so-called bone conduction or nerve transmission of sound. Then, as noted on the audiogram, the differential between the air and the bone conduction becomes lessened. When the audiogram shows an adequate air-bone gap and a reasonably flat depression of hearing in one or both ears and with a history as outlined above, it is advisable to do an exploration of the middle ear for the purpose of restoring hearing if it is feasible. The physical examination reveals usually a very clean ear canal without cerumen, a transparent membrana tympani due to atrophy of the superficial layer of epithelium and through this a very pink promontory of the cochlea. Audiograms reveal a flat depression of hearing, beginning with a more severe attack in one ear, and usually followed by a suppression in the other ear within a matter of months or years.

The operation consists in making a flap of the posterior membranous canal wall, elevating it forward to the annulus, and elevating the posterior half of the drum forward, to expose the middle ear. A small segment of bone is taken out to expose the incudostapedial joint, the crura, and the footplate of the stapes. It is at this point that the pathology may be recognized and evaluated. The surgical procedure chosen varies from this point on, depending on the amount of pathology present and its location. With a simple excrescence at the anterior crus, a simple transmission of vibration through the incus or through the head of the stapes, or by manipulating the posterior crus of the stapes, may break up

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\*Presented at the 148th Annual Meeting of the Rhode Island Medical Society, at Providence, Rhode Island, May 13, 1959.



and dislocate the pathology so that the footplate can again transmit vibration to the inner ear. If, however, pathology exists at both ends of the footplate, it is sometimes necessary to divide or remove a small segment of the anterior crus and to do the manipulation through the posterior crus alone. If both of these are so fixed, then breaking up of the footplate by microscopic picks and chisels may bring about motion in the footplate; and if all of these fail, the footplate may be removed entirely and a vein graft applied to cover the labyrinth at the point of exposure. Then a small segment of polyethylene tubing is attached to the incus and carried down into the oval window to hold the vein graft in place. This restores hearing, because it allows vibration to be transmitted again into the labyrinth. These are a few of the procedures which are feasible and which bring about an almost immediate restoration of hearing. The operation is done with only a very minute amount of local anesthesia in the ear canal; during the procedure conversation can be carried on with the patient on the table. Auditory measurements are taken during the operation and at the completion of the procedure, to measure improvement in hearing. This is later compared with the pre-operative status.

The most attractive aspect of this particular operation is that it hospitalizes the patient only about two days and sometimes even less, and then he or she is up and about at home and back to work within a very few days. There are no sutures and there is little or no dressing other than a cotton ball, although this of course is varied with the individual surgeon.

There are complications. The possibility of re-fixation of the footplate may occur and if this is so, the patient will return for a new appraisal. The operation, incidentally, may be repeated and perhaps more successfully than at the first instance, or a new approach may be made by a direct attack on the footplate. If at the conclusion of all this there is still failure, but with the proper indications for operation still holding, the fenestration procedure may take place and bring about a more successful and complete correction of the defect.

Age plays a small part in this procedure, since the operation may be done during childhood, in middle age, or even in the elderly. Otologists throughout the country are utilizing this operation many times as a preliminary to the fenestration, since through a fairly simple means the desired end result may be brought about without subjecting the patient to the more formidable fenestration procedure. Results up to about seventy per cent improvement are being obtained, with perhaps a twenty per cent loss following the first three months, and on those re-operated, a satisfactory

gain in the restored hearing of about ten per cent.

This opens up a new field for restoration of hearing in people with chronic middle ear disease. Transfer of skin grafts to close perforations in the middle ear, and the use of prostheses are all feasible; they are being used largely in this country and in Europe. Doctors Zollner and Wullstein have pioneered much of this work in Germany.

This work is made possible through the use of the operating microscope, a very fine Zeiss instrument on a floor standard which is swung into position over the patient and gives magnification of six, ten, sixteen, twenty-five or forty diameters. Needless to say, this opens up the middle ear into a brand new operative field. The new instruments which are being produced every day are legion and all of them are useful. Some of course become obsolete before the week is out, but we are always prepared for the newer techniques with newer instruments.

In conclusion, this Stapes Mobilization operation which is now approximately five years old, has brought back hearing to literally thousands of people who have had little or no help because they have shied away from the more formidable operation of fenestration. It is serving a very useful purpose, and while not perfect in its application has brought relief to many people.

#### BRONCHOGENIC CARCINOMA — PREDISPOSING CAUSES

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- 27Roffo, A. H.: Carcinoma del pulmon experimental por alquitrán tabaquico. Cancer experimental. Bol. Inst. de Med. exper. para el estud. y trat. d. cancer, 20:103-122, 1943
- 28Schrek, R.: Baker, L. A.: Ballard, G. P., and Dolgoff, S.: Tobacco smoking as an etiologic factor in disease: I. Cancer. Cancer Research, 10:49-57, 1950
- 29Sosman, Merrill C.: Personal communication
- 30Stocks, P., and Campbell, J. M.: Lung cancer death rates among non-smokers, pipe and cigarette smokers: An evaluation in relation to benzpyrene and other substances. Brit. M. J., 2:923-929, 1955
- 31Watson, W. L.: Cancer of the lung: Consideration of incidence and etiology. New York Med., 6:15-18; 40 (June 20) 1950
- 32Wegelin, C.: Der Bronchial and Lungenkrebs. Schweiz. med. Wchnschr., 72:1053-1063, 1942
- 33Wynder, E. L.: Graham, E. A., and Croninger, A. B.: Experimental production of carcinoma with cigarette tar. Cancer Research, 13:855-864 (Dec.) 1953
- 33aIdem: Experimental production of carcinoma with cigarette tar. II. Tests with different mouse strains. Cancer Research, 15:445-448, 1955

**Note: Some of the charts graphically illustrating statistics mentioned in this paper have been omitted for reasons of brevity.**

... THE EDITORS

## BUTLER HEALTH CENTER — FIRST FULL YEAR OF OPERATION\*

ROBERT W. HYDE, M.D.

The Author, *Robert W. Hyde, M.D., Superintendent,  
Butler Health Center, Providence, Rhode Island.*

LAST YEAR the RHODE ISLAND MEDICAL JOURNAL published *Butler Health Center — Today*, in which the reopening of Butler Hospital as Butler Health Center was described. We have now completed our first calendar year of full operation and it seems appropriate to describe what has occurred during this first year. This is particularly true because of the wide interest and support the Center has had from the medical profession of Rhode Island, the other citizens of this state, the U.S. Public Health Service and the American Psychiatric Association.

Another reason for such a report is the fact that Butler Health Center represents a model of modern trends in psychiatric practice. The plan for opening was based on a study made by a committee from the American Psychiatric Association and it was sponsored in many ways by the U.S. Public Health Service and the Department of Health, Education and Welfare. These trends, briefly stated, consist of application of the newly acquired armamentarium of treatment methods. These methods are founded on (1) recognition of the complex family and community circumstances involved in mental illness and 2) direction of treatment to the total situation rather than to the patient alone. These methods include recognizing a patient's abilities and the degree of actual responsibility he retains even while ill, and then furnishing varied environmental conditions which permit respect for and utilization of such abilities and responsibility. These methods also include provision for alternatives to full-time hospitalization in terms of out-patient service, day service, night service, half-way house care and provision for rehabilitation services.

The development of Butler resembles that of several other treatment centers elsewhere in America. The emphasis on milieu therapy is similar to that of the Menninger Clinic. The use of open doors, day program, and group discussions led by psychiatric nurses is also proving effective at Allen

\*From Isaac Ray Library, Butler Health Center, Providence, Rhode Island (formerly Butler Hospital).

Memorial Institute in Montreal. Intensive study of the interaction between personnel and between personnel and patients is also taking place at Chestnut Lodge. Massachusetts Mental Health Center has the most similar program with which we are acquainted, with emphasis upon almost all of the areas we mentioned, but in the setting of a small intensive-treatment state hospital with a very large and active psychiatric resident training program.

The principal divisions of clinical service at Butler are the out-patient department, the day service and the in-patient or residential service. There is a close interlocking between each service, permitting patients to be easily transferred back and forth between these services. During the year, fifteen out-patients were found to be in need of supervised living experiences and activities that could be provided by the day program, and eighteen out-patients were found in need of full-time residential service.

After residential patients no longer need full-time hospitalization, some may still need long-term rehabilitation or psychotherapy. Such patients may then return home and continue to come in for day care. During 1958, twenty-one cases came back for day care, and forty-one came back for out-patient service. Hence each of these major departments is serving far more patients than those admitted directly from the community.

In the period January 1, 1958 to December 31, 1958, these clinical services have been formally rendered to 511 different persons. Two hundred and eighty-seven were first admitted to the out-patient department, 64 to the day service, and 160 to the residential service.

The following table will show the extent to which each of these services is used. It also will show the extent to which patients are transferred from one service to another.

	Out-Patient Day Service In-Patient		
Admitted from Community	287	64	160
From out-patient		15	18
From day service	9		10
From in-patient	41	21	
Total	337	100	188

The following table shows the number of patients admitted to a given service from the outside com-

*continued on next page*

munity as compared to those coming from other hospital services.

	From Community Directly	From other Hospital Services ( Out, In, Day )
Out-patient department	85%	15%
Day service	64%	36%
Residential service	85%	15%

We can see the interdependence of these services. The day service receives 36% of its admissions from out-patient or residential service. This is largely because these patients' needs have been so thoroughly scrutinized by the hospital staff that the value of the day program for them is recognized. On the other hand, for a new patient coming to Butler Health Center without any previous complete evaluation, the value of this service cannot be immediately recognized. It is the newest program and its full range of usefulness is being determined.

#### Source

The geographical source of patients varied in the three services:

	Out	Day	In	Total
Providence	169	60	58	287
Rest of Rhode Island	155	40	112	307
Outside Rhode Island	13	0	18	31

As might be expected, the day program is particularly used by people of Providence because of transportation ease, while the use of the residential service is more representative of the population of the state. The out-patient service is intermediate in this respect.

The source of referral likewise differed in the three services. The out-patients were referred about equally by Providence physicians, Butler in-patient service, psychiatric associates of Butler and other Rhode Island physicians.

#### REFERRAL SOURCE

	Out	Day	Residential
Psychiatric associates of			
Butler	28	8	83
Consultants	6	0	6
Other R. I. psychiatrists	13	4	12
Other Providence physicians	37	3	28
Other R. I. physicians	24	1	19
Psychiatrists out-of-state	5	1	4
Physicians out-of-state	4	0	7
Division of Vocational			
Rehabilitation	89	47	
Day patient	9		10
Out-patient		15	18
In-patient	41	21	
Social agencies and other	81	0	1
Total	337	100	188

In-patients came predominantly (83 or 44%) from our associate psychiatrists, 28 or 15% from out-patient or day service. These figures show the

degree to which the residential service supports the out-patient and day service (as well as the private practice of our associates) in those cases needing full hospital treatment.

The greatest number of day patients (47) came from the State Division of Vocational Rehabilitation, twenty-one came from the in-patient service and fifteen from out-patient. A total of sixteen came from our associates and other Rhode Island physicians.

Of the 83 patients referred by our associates, 66 were treated by them while in the hospital. Of the 188 individuals admitted to residential service, 135 or 72% were voluntary admissions and 53 or 28% were committed. This high proportion of voluntary admissions well indicates the degree to which patients participated voluntarily in their own treatment plans.

#### Age and Sex Distributions

Patients from twelve years of age upward are accepted for full twenty-four hour hospitalization, day service, or out-patient service. A limited service is provided to a few patients under twelve in the out-patient department. Because of the absence of other private facilities for the twelve- to eighteen-year group and the particular demand for these services, patients in this age group have made use of all three services.

The patients served ranged in age from 6 to 92. Out-patient, 179 males and 158 females; day patient, 43 males and 57 females; in-service, 51 males and 137 females.

#### AGE GROUPS

	Out	Day	Residen- tial	Total
Under 12	10			10
12 to 18	59	19	18	96
19 to 65	260	76	138	474
Over 65	8	5	32	45
Total	337	100	188	625

#### SEX

	Out	Day	Residen- tial	Total
Males	179	43	51	273
Females	158	57	137	352
Total	337	100	188	625

#### Diagnostic Facilities

During 1958, the diagnostic facilities of the Center were increased substantially. A new eight channel (expandable to sixteen) electro-encephalograph was purchased, a new basal metabolism unit was donated by the auxiliary. Additional consultants in ophthalmology, anesthesiology, dentistry, and dermatology were appointed. Procedures for study of

*continued on page 517*



# BUTLER HEALTH CENTER— FIRST FULL YEAR OF OPERATION

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children, adolescents and older patients were developed. Rehabilitation evaluations were made more effective through fuller integration of the examinations made by psychologist, psychiatrist, social caseworker, rehabilitation counselor, and sociologist.

The diagnostic facilities of the Center: clinical, laboratory, psychology and social service departments are equally available to all three major services: out-patient, day service, and residential service.

Although a considerable number of the patients admitted have had extensive evaluation by the referring physician, many others are admitted originally for evaluation. A fundamental part of the service given by the Center was that of diagnostic evaluation.

## DIAGNOSTIC STUDIES DONE IN 1958

	Out-Patient	Day Service	Residential Service	Total
Urine examination	0	12	200	212
Blood examination	17	101	552	670
EKG's	7	3	88	98
EEG's	1	2	13	16
Basal metabolism	0	1	5	6
Physiological (Funkenstein, etc.)	0	2	11	13
X rays	20	8	431	459
Psychological	30	25	70	125
Social service	148	74	228	450

A comparison of the diagnoses of these patients admitted to the three departments of the Center shows the type of problem each department has been treating during 1958.

	Out-Patient	Day Service	In-Patient
Chronic brain syndrome	17 (5%)	7 (7%)	13 (7%)
Affective reaction	34 (10%)	14 (14%)	55 (29%)
Schizophrenic reaction	37 (11%)	24 (24%)	41 (22%)
Psychoneurotic	66 (20%)	21 (21%)	46 (24%)
Personality disorder	90 (27%)	26 (26%)	30 (16%)
Adjustment reaction	27 (9%)	6 (6%)	
No diagnosis	45 (12%)	2 (2%)	2 (2%)
No disease	8 (2%)		1 (1%)
Testing only	13 (4%)		
Psychotic reactions	26%	45%	58%
Non-psychotic reactions	56%	53%	40%
Others	18%	2%	2%

It is interesting that there is a considerable similarity in the seriousness of disorders treated in the three departments. 58% of in-patients, 45% of day service, and 26% of out-patients have psychotic reactions.

We so often assume that out-patient departments serve only psychoneurotics. Actually 20% of the out-patients were psychoneurotics and 26% psychotic. One service of the out-patient department is that of evaluation, testing, etc. 18% of the out-patients tested showed no disease.

Perhaps the most surprising fact is that a greater proportion of day service patients had schizophrenic reactions (24%) than in-patients (22%) or out-patients (11%). We have become so accustomed to think of schizophrenic patients as requiring hospitalization that it is somewhat surprising to see them more commonly in the day program and out-patient department.

We think of finding psychoneurotic reactions rarely in a hospital population, but here we find slightly more than in the other services: in-patient 24%, day service 21%, out-patient 20%. In attempting to understand this, we find the largest number of the in-patient and day service psychoneurotic reactions were depressive reactions; day service 12 of 21 (57%), in-patient 27 of 51 (54%), out-patient 29 of 72 (40%). It appears that for this category the suicidal risk coupled with the effectiveness of removal from the precipitating situation frequently leads to hospitalization or day service. It is notable that the affective psychotic reactions tended to be more frequently cared for in the in-service (29%) than day service (14%) or out-patient (10%), doubtless for the same reasons.

## Who Were Patients Treated By

The medical staff of Butler Health Center includes twenty-nine consultants (four in psychiatry), twelve psychiatric associates, and two medical associates in addition to its full-time staff of four psychiatrists. These psychiatric associates and psychiatric consultants in practice in the community, can treat their patients at Butler in all three services: out-patient, day service and residential service.

This practice, which is beginning to develop in some other mental hospitals of the country, has the obvious advantages of preserving the patient's relationship with his physician, or thereby making the hospitalization or day hospital service an episode in the patient's total treatment. This continuity of service appears to reduce the threat of hospitalization, insure after care and thereby shorten and improve the patient's treatment.

Perhaps the most important trend occurring during the year was the increase in the number of patients referred by and treated by our own psychiatric associates. During the first six months of the year, of sixty-nine patients admitted, nineteen had been referred by our associates and ten were treated by them. During the last six months of the year, of 119 admissions, our associates had referred sixty-four and fifty-six were treated by them. This means that roughly 25% of the patients in the hospital at any one time are being treated by our psychiatric associates.

In addition to this, one of our associates in internal medicine assumed the responsibility for the

*continued on next page*

medical problems of our geriatric patients. The number of these patients in the hospital at any one time increased from six in January to twelve for the months of September to December.

This leaves the full-time psychiatric staff with little increase in treatment responsibility through the year in spite of a substantial increase in number of in-patients. An important part of our work thus became the development of smooth co-operation between our associates, the nursing staff, and ourselves.

This degree of participation of sixteen community psychiatrists (twelve associates, four consultants) in the work of Butler Health Center makes it a center of psychiatric service rather than a separate hospital conducted by only the full-time staff. In this respect Butler Health Center differs from most private mental hospitals.

### *Treatment*

A broad spectrum of treatment is represented by the twenty psychiatrists who have been treating patients at Butler during the past year. This shows that psychiatry today is tending away from dogmatic and sectarian adherence to one limited type of treatment and toward an acceptance of all methods of social management, psychotherapy and somatic treatment as needed. It appears that all psychiatrists utilized all treatment methods. This observation deserves further documentation, for it shows that psychiatry is coming into a mature status as a medical specialty.

PATIENT TREATMENT

	Out-Patient	Day Patient	In-Patient
Individual psychotherapy	150	40	61
Group psychotherapy	26	53	56
Psychiatric casework with relatives	23	36	57
Psychological counseling	12	14	11
Milieu therapy (organized)	...	...	26
Milieu therapy (informal)	...	...	50
Phrenotropic agents	5	39	54
Electric convulsive therapy	26	53	56

*Psychotherapy* varies in frequency, one to five times weekly. It is usually conducted by a psychiatrist, but often by a psychologist or a social caseworker under psychiatric supervision. Individual psychotherapy has become increasingly important, in part because the use of chlorpromazine can now render psychotic patients more accessible to the psychotherapist.

*Psychopharmacology*, the use of the newer drugs which act as psychic energizers or tranquilizers, follows accepted patterns. However, we have applied the results of research conducted on non-patient subjects by our research team. This research has particularly concerned the effects of Chlor-

promazine and Reserpine, which appear to be our most valuable drugs. There has been considerable trial of the selected use of Meproamate, Ritalin, Marsilid. The need for the use of these drugs as a part of a total treatment procedure has been constantly recognized. The use of a drug which alters the patient's acceptance of people requires special attention to his environment so that his response, when altered, can be directed towards appropriate people. Chlorpromazine was equally useful with many older agitated patients, producing sufficient relaxation so that they could engage in activity and socialization, which for many was centered in the homecraft program in occupational therapy. Others received more comfort from Reserpine.

*Electric convulsive therapy* had its place where there were deep depressions, and sometimes where the above combination of chlorpromazine with either psychotherapy or milieu therapy was unavailing.

*Group Psychotherapy* has taken the conventional form of small, closed groups, and has followed the methods of open group psychotherapy developed by Doctor Bockoven at Massachusetts Mental Health Center. It has also included groups with more circumscribed goals pertinent to rehabilitation. One group, led by a psychiatric caseworker, focused particularly upon the area of family adjustment, another, led by a rehabilitation counselor, focused particularly upon work attitudes and motivation; another, led by a physical therapist, and composed of patients with predominant physical disabilities, focused upon patients' reaction and adjustment to their disabilities. All the group therapists were supervised regularly by a psychiatrist with group psychotherapy experience.

"*Milieu therapy*" is primarily the province of the nursing service and the occupational therapy department. Conducted under psychiatric supervision, guidance and prescriptions, it consists of providing the in-patient and day patient with an hour-by-hour experience that is valuable to him therapeutically, that is individualized, and that respects his needs. This can be done only in a treatment unit with a co-operative investment in the treatment program, which includes rapid communication between patients and personnel, and between all elements of personnel: doctor, nurse, L.P.N.'s, attendant nurses. It requires an open door (controlled where indicated) nurses out of uniform, utilization of the facilities (churches, schools, stores, theaters) in the community, and co-operative planning among doctors, nurses and patients in the use of these outside facilities. A broad program of opportunity for supervised experience must be available through co-operation among occupational therapy, nursing and physical therapy personnel under psychiatric supervision. This must provide for occupation, avoca-



tion, education, recreation, relaxation as indicated. An addition this year has been a school teacher to provide conventional educational opportunity.

Milieu therapy became increasingly effective as the clinical team became more experienced in working together. It required frequent discussions, usually led by a psychiatrist or nursing director, with the goal of learning the views of personnel with respect to each patient's needs and of arriving at a consensus of opinion as to what action would motivate the patient in the direction of mental health. Such discussions in themselves stimulate personnel to serious thinking about patients and raise the patients' value as members of the hospital community.

### *Out-Patient*

The work of the out-patient department was extended through the service of several of our associates in psychiatry, as well as that of part of the time of all four of our full-time staff. A full-time psychiatric caseworker, psychologist and secretary make up the rest of the staff.

A total of 337 different persons were admitted during the year, of whom 132 were in the clinic for evaluation only, while 205 were engaged in treatment. A total of 2,510 hours of clinical service were given of which 2,129 was for treatment visits for the 205 patients in treatment, or an average of 10.4 treatment hours per person.

In determining the function of the out-patient department, it is seen that one of the most important (132 patients) is that of diagnostic evaluation. To have an opportunity for diagnostic study without hospitalization avoids much unnecessary discomfort, fear, and disruption of family life.

For the forty-one patients coming to the out-patient department from the residential service, the continuing treatment in the out-patient department made it possible for these patients to leave the hospital and return to their homes earlier. Furthermore, it provided the long-term treatment necessary to bring about those fundamental changes which decrease the possibility of any recurrence of illness.

One of the primary functions of the out-patient department is to serve persons who might otherwise require hospitalization or who have difficulties of a nature that might lead to hospitalization if they do not receive help at the proper time. This is possible where the patient's relationship with his psychotherapist provides the support and understanding that he needs. It also occurs where the social caseworker, in conjunction with the psychotherapist working with the patient, support the family and produce an improved home situation. The Butler out-patient department served this function for ninety patients.

Out-patient treatment was found to be particularly useful where the patient needed to continue his relationship with employer, family, or community groups, but required additional support and assistance to do this. In many cases success depends upon the patient's maintaining confidence, self-esteem, and the sense of accomplishment which he achieves through remaining in community life. Here out-patient treatment has definitive value.

Many of the patients are incapacitated in a way that, although not leading to imminent hospitalization, has led or is leading to loss of employment and support of families with children. In other cases the patient's behavior causes injury to children.

In contrast to hospitalization, out-patient treatment affects only a segment of the patient's social and psychological life. Thus the patient still maintains essential areas of competence. These segments of disorder may be in relations with school, marriage, children, work, friends. Here out-patient treatment is usually sufficient and has the advantage of preserving the remaining areas of satisfactory adjustment. There were sixty-seven people during the year who, although able to work and maintain family life in a fair way, were living much less than a full life because of periods of despondency, acute anxiety and uneasiness in relations with others. These people were helped to overcome these handicaps.

### *Day Program*

The Day Program developed during 1958 with a clinical team of psychiatrist, psychiatric nurse, social caseworker, and secretary.

The activity program used by day patients is the same as that used by residential patients and was provided by occupational therapists, home craft teacher, woodworker, printer, and arts and crafts instructor; it received assistance from a large corps of volunteers and the maintenance, housekeeping and dietary departments of the Center.

Group psychotherapy became an outstanding feature of the program with four groups in operation. A new service was the development of a school with nine pupils studying a wide range of subjects.

The total number of patients on the program throughout the year was 121. This includes twenty-one patients carried over from the previous year and 100 different persons admitted in 1958. It represented a "half-way house" type of service for twenty-one in-patients who were not ready to take up full community responsibility. These patients would have had to stay in the hospital longer if the day program had not been available. For the fifteen patients received from the out-patient department, it represented an additional service of socialization and support, often providing an alternative to hospitalization.



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## DR. OCHSNER, LUNG CANCER AND TOBACCO

IT IS ENCOURAGING to know that the Fiske Fund Prize essay contest, first established in 1835, has maintained its vitality through the years despite the modest stipend offered. Even though the contest in recent years has attracted entries from as far away as the Pacific Northwest, it is still no accident that Doctor Alton Ochsner of New Orleans saw fit in his maturity to turn his brilliant hand toward this endeavor. Printed elsewhere in this issue is his prize essay *Bronchogenic Carcinoma — Predisposing Causes*. In it he espouses a cause for which he has been a strong adversary for a number of years.

The question of lung cancer and cigarette smoking has been discussed previously in these columns on several occasions. In the issue of April 1957, it was stated that: "The evidence of a relationship between smoking and lung cancer . . . seems to be increasing." In November of the same year the following statement appeared: ". . . we are now at a point at which it can be said that smoking, cigarette smoking in particular, is one of the factors, possibly the most important factor, in the causation both of bronchogenic carcinoma and of chronic obstructive emphysema."

The further impressive marshaling of evidence in this brief monograph on the relationship between lung cancer and cigarette smoking comes to our editorial advertence, therefore, not as a revelation, but rather as final confirmation of a proposition

already stated. We congratulate Doctor Ochsner, not only for winning the current Fiske Prize, but even more for bringing to us this timely message.

### PHYSICIAN SUPPORT OF MEDICAL SCHOOLS

Only Alaska had fewer physician contributors to the American Medical Education Fund than did Rhode Island in 1958.

On the surface this bare statement of fact might be interpreted to indicate a lack of financial support of medical education by the doctors of Rhode Island. Nothing is farther from the truth. For reasons best known to themselves, our members prefer to contribute directly to the medical school of their choice through direct donation to alumni funds, rather than through the mechanism of the AMEF.

A study of the 1958 statistics released by the Foundation provides some interesting data on the role that Rhode Island physicians played in helping medical education last year. For example, the national average for the individual contribution to all funds collected, by the Foundation and through Alumni programs, was slightly over \$39. The Rhode Island individual average was almost \$43.

A total of 418 Rhode Island physicians contributed \$17,922.67, of which \$17,030.67 was given directly to medical school alumni funds by 387 doc-

tors, and the balance represented AMEF contributions.

Thirteen states contributed less than Rhode Island, and three, with more contributors and larger medical populations, were not far ahead of us. West Virginia, with 64 more contributors bested our total by only \$609; Mississippi, with 208 more doctors giving, had only \$1,774 more in its total; and Utah, with 310 more doctors aiding, contributed only \$6,068 more than Rhode Island.

It is of little matter how the funds are donated as long as there is continuous support of the medical schools in their efforts to continue their work on a free and independent basis with a minimum of support from federal tax sources.

Our breakdown of the 1958 medical school contributions is presented only to emphasize anew that the doctors in Rhode Island have, as always, done their share in the financial giving for medical education.

### MEDICINE AND OSTEOPATHY

The relations between medicine and osteopathy came up for review again at the recent annual session of the American Medical Association, and apparently another step was made which may eventually result in the transfer of the osteopathic colleges into the realm of accredited medical schools.

Underlying the efforts to reconcile differences between osteopathy and medicine is the fact that one fourth of the states still have restrictive legislation relative to the extent to which osteopaths may practice the healing art. The position of medicine remains unchanged in its objection to systems of healing practiced as medicine by practitioners without the same educational standards as a doctor of medicine.

In the opinion of the A.M.A. House of Delegates, as indicated in the adoption of the reference committee report of the Judicial Council's activities, "in each state there should be established one educational standard in the field of the healing art administered by a single licensing board by which anyone who is authorized to practice the healing art should be required to prove he has secured satisfactory training in the fundamentals of medical science."

Further, the Judicial Council expressed the opinion that osteopathic colleges, and indeed all colleges teaching the healing art or any of its branches, should be inspected and classified according to the same standards of measurements now being applied in medical schools and by the same boards which approve medical schools.

As a step to encourage osteopathic colleges to make this change, the A.M.A. House adopted a statement of policy indicating that it shall not be

considered contrary to the principles of medical ethics for doctors of medicine to teach students in an osteopathic college which is in the process of being converted into any approved medical school under the supervision of the A.M.A. Council on Medical Education and Hospitals.

The American Osteopathic Association, through its policymaking body a year ago, amended its constitution to define its objects to promote public health, to incorporate scientific research and to maintain and improve high standards of medical education in osteopathic colleges. Thus, the influence of founder Andrew Taylor Still gave way to the new concept of osteopathy as ultimately becoming part of medicine.

It is to be hoped that out of the latest action of the A.M.A. may develop a liaison committee with the osteopathic association that will consider problems of common concern, including interprofessional relationships on a national level.

Doctor Oliver Wendell Holmes, in one of his addresses, urges his hearers not to look with contempt on their old medical books. "The debris of broken systems and exploded dogmas," he continues, "forms a great mound, a Monte Testaccio of the shards and remnants of old vessels which once held human beliefs. If you take the trouble to climb to the top of it, you will widen your horizon, and in these days of specialized knowledge your horizon is not likely to be any too wide." Now that the period of purely professional education has been prolonged, the tendency to this narrowness of view is likely to increase, and no better antidote could possibly be found than the study of medical history, a subject which makes us acquainted with the most diverse forms of thought and brings before us every phase of civilization.

EDWARD THEODORE WITHINGTON, M.A., M.B.  
*Medical History*

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**WEDNESDAY . . . SEPTEMBER 23**

## DETAILING IS ALSO PUBLIC RELATIONS\*

MARC WOODWARD

The Author. *Marc Woodward, of New York, New York, Assistant Executive Director, Health News Institute, New York.*

IT IS A real pleasure here today to have the opportunity to meet with you and give you some of my ideas about public relations in the health field.

From the title of my talk it might be suspected that I know something about the profession of the medical service representative, or detail man, if you will.

I know very little about it. About all I know is that the detail man comes in contact with the most important customers that the purveyors of medicine have—the doctor, the pharmacist, and the hospital—and that his approach to them must, of necessity vary.

Nevertheless, they—the doctor, the pharmacist, and the hospital, together with the detail man's boss, the manufacturer—constitute a team. A team that administers to the health of our country.

Now, for some years that team has enjoyed a rather special privilege of immunity from criticism from the press, the government, and the general public. Starting a couple of years back, this very special situation began to undergo a marked change. The year 1958 saw considerable criticism in the press of the cost of being sick. This criticism was directed at all of the members of the health team. And 1959 will witness even more criticism.

As John T. Connor, president of Merck & Co., put it recently in a speech to the New York Board of Trade, "It is the year the public comes to call. This is the year the public walks into our house and takes a look around. So much of our future is dependent on how we respond to this experience." Mr. Connor said, "that I can think of no subject that deserves a higher priority for our discussion."

Pointing out the various governmental investigations of the pharmaceutical industry under way, such as hearings on drug prices, investigation of polio vaccine sales, patents, antibiotics, Mr. Connor said, "As the crowd collects around our house and

the television cameras move in, we can be sure that we will find ourselves entertaining several other gentlemen with an occupational fondness for the warm glow of the klieg lights."

Doctor Linwood Tice, in an editorial appearing in the December, 1958 *AMERICAN JOURNAL OF PHARMACY*, put it a little more strongly when he said:

The philosophy behind the criticism of the drug industry is in keeping with the times for it has become good statesmanship in America to give the masses what is popular and what they want regardless of how wrong it is or how harmful to the country. It is this sort of political expediency and chicanery which keeps the national budget unbalanced in times of unprecedented prosperity, permits the most unbelievable excesses in certain corrupt labor unions, and fails to recognize our most serious national weaknesses such as in education and civil rights.

It is very good politics to criticize the drug industry since the average man is never happy about the outlay of a few dollars for drugs, even though it saves his life. The thousands he spends for a chrome-bedecked and gadgeted monstrosity called an automobile, he spends gladly and even goes in debt willingly to obtain. For such an over-priced luxury, his interest and carrying charges alone per year exceed his annual drug bill, but he gives this no thought at all.

I must say here, however, that the drug industry is not alone as a target for criticism.

### *Hospitals and Medical Profession Subject to Attacks*

Recent years have witnessed nagging attacks by certain government personnel and agencies against the medical profession. The press has not been too kind in this direction either. The attack seems to be against "organized" medicine. What the critics don't seem to take into account is that medicine in this country is organized as much for the protection of the patient as it is for the doctor. We would not enjoy such benefits as emergency call service or the reduction of fees for lower income bracket patients if it were not for the fact that our doctors get together and iron out these problems. And don't

\*An address delivered at the Second Annual Medical Service Representatives Conference, 148th Annual Meeting of the Rhode Island Medical Society, at Providence, Rhode Island, May 12, 1959.



For arthritic M.S.:  
full corticosteroid  
benefits from new  
Gammacorten<sup>T.M.</sup>



Patient M.S., 81, at the time of the first visit was in severe pain and very uncomfortable. Complained of swelling of wrists, legs and various joints; pain and stiffness in cervical area and lower spine; pain, swelling and limited motion in the fingers; slight ulnar deviation of the hand. M.S. demonstrates position necessary to put on his hat. Motion was so restricted that he could not comb his hair).

Treatment and Result: After 36 hours of GAMMACORTEN therapy, M.S. had "complete relief." Joint swelling had decreased, pain was almost absent, range of motion had increased dramatically. At the end of the first week of GAMMACORTEN he was free of discomfort and able to return to his job as a porter. M.S. could put on his hat normally, could comb hair; joint function near-normal after first week.

## Gammacorten<sup>T.M.</sup>

(dexamethasone CIBA)

- potent, effective corticosteroid
- profound anti-inflammatory activity
- minimal side effects

From the files of a practicing physician. Photographs used with permission of the patient.

SUPPLIED: GAMMACORTEN Tablets, 0.75 mg. (pink, scored).



C I B A

SUMMIT, N. J.

## DETAILING IS ALSO PUBLIC RELATIONS

*continued from page 522*

forget that every county medical society has a board of censors for the express purpose of disciplining its own membership.

The hospitals, too, have recently come under attack. A national magazine, only this past winter, devoted a substantial number of pages to criticizing hospital practices, but based its article on case studies representing a small percentage of patients. A very recent series of articles in a New York newspaper reported in considerable detail the unfavorable aspects of the operations of an over-worked hospital.

So, you see, we are all in it together. And the only way to set the record straight is for every member of the health team to keep every other member in mind at all times. Everyone concerned with the nation's health, from Surgeon General Burney right down to the last assembly line operator on a tablet-processing machine, has a responsibility to help keep the record straight. This responsibility is not necessarily only to one's employer, but to keeping the public informed of the facts, meanwhile remembering the other members of the team.

Today's public has a consuming interest and curiosity about its own health. It has satisfied this curiosity to the extent of learning what some drugs and medical advances have accomplished about curbing suffering and extending the life span. But it knows next to nothing about how these accomplishments have come about from the scientist's conception to the bedside of the patient.

And the public has the right to know.

All right, how is it going to learn?

Are we, the members of the health team, going to leave it to the self-seeking politicians who instigate inquiries for their own aggrandizement, to explain to their constituents the complexities of medical care?

Or are we going to leave it to certain elements of a headline-seeking press to assess the costs of medication, hospitalization and doctor's fees?

I doubt that anyone in this room would, if he seriously looked into these problems, want to forfeit that responsibility.

A little over three years ago a group of thoughtful and enterprising men in the pharmaceutical manufacturing field came to the conclusion that public attitudes had developed toward the entire medical care situation in this country to the point that something should be done about it—and right away. As a result, the Health News Institute came into being, under the direction of Chet Shaw.

The Health News Institute has had as its objective the presentation to the public of a true picture

of the research, production and distribution operations of pharmacy and pharmaceutical manufacturing and the health team in general, and the creation of a better understanding of their contributions to the nation's health.

We maintain continuous liaison with all members of the health team in this effort to account to the public for the total contribution which is so vital in our present standard of living. We try to crossfile information and conduct informative relationships mutually with other segments of the health field in order that the same story will be told from an objective and factual point of view.

I must say we have had magnificent co-operation from the other elements of both the pharmaceutical industry, from manufacturers to small-town pharmacists, and the medical profession, in this effort.

But in our opinion, no segment of the team can disassociate itself from any other segment. When one member is attacked, all suffer.

You may ask right here, "Why has all this criticism come about?"

There's an answer and a good one. Let me give you an example.

It goes back to the old army saw that if you never volunteer you never get into trouble. Just so, if you do nothing, no one pays any attention to you.

But the field of health and medicine has made tremendous progress since World War II, thereby attracting notice . . . some of it good and some of it bad. It is usually the bad that sticks in the public memory. Like a little scandal surrounding the family of an eminent man. The public finds it easy to forget his accomplishments if his son turns out to be a bigamist.

It was only when the pharmaceutical industry grew big enough to really be considered a national asset of significance; whose daily contributions to the battle against disease became well known to our own public, that it was subjected to closer scrutiny.

### *Role of Detail Man*

Now, I'll get down off the soapbox and we'll take a look at where the members of the health team can be useful in telling our story. Specifically, in this instance, the detail man who works for a manufacturer of medications.

First, since the detail man meets the ultimate customer—the doctor or the pharmacist or the hospital procurement department—he is in an ideal position to be a missionary.

Here for the sake of argument and to emphasize a point, let's play with some figures. I'm no mathematician, but I've found that you can make statistics and figures work for you.

There are some 15,000 detail men in this country operating five days a week average. Even if they only make five calls a day it means they can see

*continued on page 526*



*Don't forget, Doctor —  
"to take some of your own medicine!"*

On vacation — at the beach — on the golf course — or gardening in your own back yard, sunburn, insect bites, cuts and abrasions are all part of the summer picture.

A handy tube of Xylocaine Ointment means prompt relief of pain, itching and burning for your patients. After you've seen to your patients' comfort, remember that tube of Xylocaine Ointment for yourself.

Just write "Xylocaine Ointment" on your Rx blank or letterhead, and we will send a supply for you and your family.



Astra Pharmaceutical Products, Inc., Worcester 6, Mass., U.S.A.

## **XYLOCAINE<sup>®</sup> OINTMENT**

(brand of lidocaine\*)

### **2.5% & 5%**

### **SURFACE ANESTHETIC**

\*U.S. Pat. No. 2,441,498    Made in U.S.A.





## DETAILING IS ALSO PUBLIC RELATIONS

*continued from page 524*

75,000 Americans every day. Working five days a week they can make 375,000 contacts a week or 18,750,000 contacts a year—more than one tenth of our population. (I'm giving each detail man a two-weeks' vacation, you understand.)

That one tenth of the population is vital because they are the men and women who are most directly concerned with our health standards. They are the doctors, the pharmacists and the hospital personnel who determine what medications patients consume. In 90 per cent of the cases the patient doesn't choose the product or determine the therapy to be used against his particular illness.

You may well ask then, "So what's our story?"

The story is this:

First, the pharmaceutical industry is already subject to extensive and detailed government regulations of many kinds, some of which are unique in American manufacturing.

Next, the risk of product and production obsolescence is present in a special degree since the pace of new discovery leading to such obsolescence is rapid. Then too, there is the risk of unsuspected side effects.

Third, and related to the risk factor, is the elaborate quality control and testing procedures in which costs are extremely high in relation to manufacturing costs in other industries.

## relief from all cold symptoms Tussagesic® *decongestant, non-narcotic antitussive, analgetic, expectorant*

*Each timed-release tablet provides:*

Triaminic® .....	50 mg.
(phenylpropanolamine HCl).....	25 mg.
pheniramine maleate .....	12.5 mg.
pyrilamine maleate .....	12.5 mg.
Dormethan (brand of dextromethorphan HBr) .....	30 mg.
Terpin hydrate .....	180 mg.
APAP (N-acetyl-p-aminophenol) .....	325 mg.

*Dosage:* One Tussagesic tablet in the morning, mid-afternoon and evening, if needed.

Also, for patients who prefer liquid medication:  
TUSSAGESIC SUSPENSION.

SMITH-DORSEY • Lincoln, Nebraska  
a division of The Wander Company

Next, the control of shipments is of the utmost importance, a factor which is probably unique in American industry.

Then there is the level of research expenditure as a proportion of the sales dollar. This percentage is estimated at from seven to nine per cent for the research in medicinal production and development, as compared to an average of about two per cent for general industry research expenditures in the United States.

As a matter of fact, the Pharmaceutical Manufacturers Association this year estimated that to obtain only one drug for clinical investigation, some 60 substances on the average were prepared and biologically tested. Forty-four completely new chemicals (of a total of 370 new medicinal products marketed in 1958) were introduced by the industry last year, of which 16 came from non-U. S. sources and six represented minor modifications of older drugs.

Thus, it can be said that the expenditures during previous years of the U. S. pharmaceutical industry in research and development—and this ran over 170 million dollars in 1958—resulted in market introduction last year of from twenty to thirty really new drugs. Each new drug marketed can be regarded as having had back of it some six million dollars in total industry research and development expenditures *as its share of the combined research effort*.

The next point I would like to mention is that special problems in education of doctors, pharmacists and hospital personnel are faced by the pharmaceutical industry.

Nearly half the time a doctor learns of a new drug through the personal visit of the detail man. Few laymen realize how heavily the burden of keeping up with medical advances weighs on doctors. The doctor cannot practice medicine just as he learned it in medical school. Yet, surveys have found that his time is so taken up that the average doctor can spend only a little over half an hour a day reading medical journals, looking at mail, and interviewing detail men.

This education of doctors in connection with new products and new types of therapy is to some extent unique in character. It is, of course, generally tied in with advertising. And I am speaking here principally of ethical drug products advertised only to the medical profession and to the profession of pharmacy. This alone makes drug promotion and advertising quite different from that of other industries. This absence of consumer advertising at times may result in conflicts with the lay press in premature and perhaps exaggerated reporting as to the uses and effects of new drug discoveries.

There is, however, no need for such a situation to become a conflict within the health team itself.

*continued on page 530*

**A NEW USE  
FOR VESPRIN**

**FROM:  
ANXIETY  
AND TENSION  
TO: EMOTIONAL  
STABILITY**

# VESPRIN

SQUIBB TRIFLUPROMAZINE HYDROCHLORIDE

made the difference  
in anxiety and tension states / psychomotor agitation /  
phobic reactions / obsessive reactions / senile agitation  
/ agitated depression / emotional stress associated with a  
wide variety of physical conditions

In the patient with anxiety and tension symptoms — Vesprin calms him down without slowing him up...and does not interfere with his working capacity. Vesprin permits tranquilization *without* oversedation, lethargy, apathy or loss of mental clarity.<sup>4</sup>

And Vesprin exhibits an improved therapeutic ratio — enhanced efficacy with a low incidence of side effects; no reported hypotension, extrapyramidal symptoms, blood dyscrasia or jaundice in patients treated for anxiety and tension.<sup>1,2,3</sup>

**dosage:** for "round-the-clock" control — 10 mg. to 25 mg., b.i.d.; for "once-a-day" use — 25 mg. once a day, appropriately scheduled, for therapy or prevention. **supply:** Oral Tablets, 10, 25 and 50 mg., press-coated, bottles of 50 and 500; Emulsion (Vesprin Base) — 30 cc. dropper bottles and 120 cc. bottles (10 mg./cc.). **references:** 1. Stone, H.H.: Monographs on Therapy 3:1 (May) 1958. 2. Reeves, J.E. Postgrad. Med. 24:687 (Dec.) 1958. 3. Burstein, F.: Clinical Research Notes 2:3, 1959. 4. Kris, E.: Clinical Research Notes 2:1, 1959. <sup>1</sup>VESPRIN® is a Squibb Trademark.

**Vesprin — the tranquilizer that fills a need in every major area of medical practice**

**SQUIBB**

Squibb Quality —  
the Priceless Ingredient



NOW... SAFER, EFFECTIVE TRANQUILIZER THERAPY

tranquilization

anti-emetic

greater specificity  
of tranquilizing action  
—divorced from such  
"diffuse" effects as  
anti-emetic action  
—explains why

 **Mellaril<sup>®</sup>**

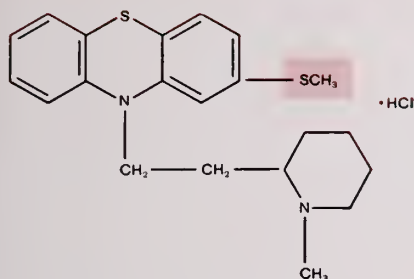
THIORIDAZINE HCl

is virtually free of such toxic effects as • jaundice • Parkinsonism • blood dyscrasia

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines. ... This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."<sup>1\*</sup>

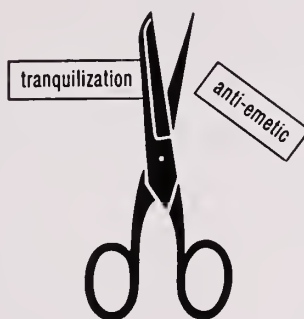
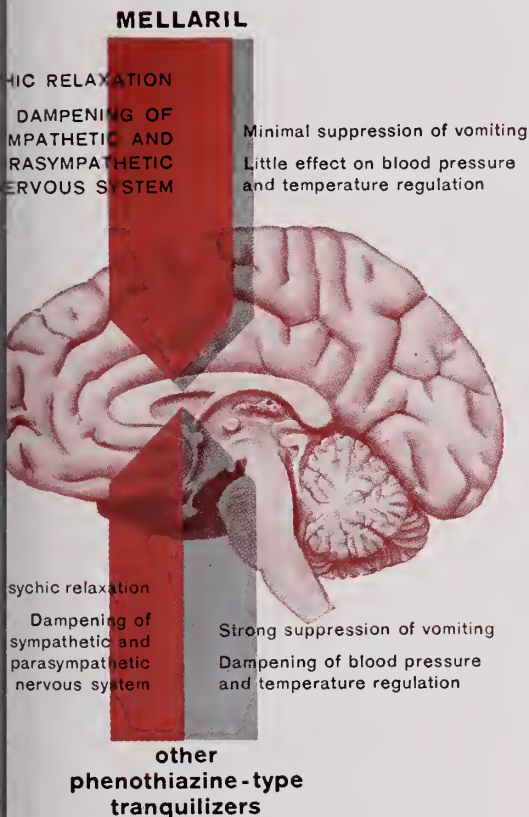


# new advance in tranquilization: greater specificity of tranquilizing action results in fewer side effects



*The presence of a thiomethyl radical (S-CH<sub>3</sub>) is unique in Mellaril and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:*

- 1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.



- 2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.
- 3 A notable absence of extrapyramidal stimulation.
- 4 Lack of impairment of patient's normal drive and energy.
- 5 Virtual freedom from such toxic effects as jaundice, photosensitivity, skin eruptions, blood forming disorders.

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
<b>ADULTS:</b> Mental and Emotional Disturbances: <b>MILD</b> — where anxiety, apprehension and tension are present <b>MODERATE</b> — where agitation exists in psychoneuroses, alcoholism, intractable pain, senility, etc. <b>SEVERE</b> — in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.: <div style="margin-left: 100px;">Ambulatory</div> <div style="margin-left: 100px;">Hospitalized</div>	10 mg. t.i.d. 25 mg. t.i.d.  100 mg. t.i.d. 100 mg. t.i.d.	20-60 mg. 50-200 mg.  200-400 mg. 200-800 mg.
<b>CHILDREN:</b> BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

MELLARIL Tablets, 10 mg., 25 mg., 100 mg.

Field, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959



## DETAILING IS ALSO PUBLIC RELATIONS

*continued from page 526*

The American Medical Association reported on a survey they had made last year, saying that most drug companies spend less than an average of five per cent of the retail sales price to advertise and promote their products.

If this expenditure were eliminated a fifty-cent capsule would cost about forty-eight cents. But this would eliminate the means necessary to produce mass volumes sales, without which the cost of producing the same capsule would not have been brought down to the fifty-cent level in the first place.

### *Cost Factor in Drug Manufacture*

The price of drugs is a constant nag because it is ill understood by the public. Yet ours is a system in which price decreases are the rule rather than the exception. Antibiotics, vitamins, hormones and steroids have all gone down precipitously in price since their introduction and are at the lowest price levels in history.

Doctor Paul Olsen, of *Drug Topics*, last month estimated that the average price of a prescription drug in 1958 was only \$2.78. THE AMERICAN DRUGGIST magazine estimates the average price at \$3.08, so it must be somewhere around the \$3.00 level.

David Stiles, director of marketing development for Abbott Laboratories, conducts a yearly survey of some 200,000 prescriptions. His last survey revealed that ten per cent of all prescriptions cost a dollar or less. Over 66 per cent were three dollars and under. Over 88 per cent were five dollars, or less. Only one per cent of 200,000 prescriptions were over \$10 in price.

Another item I believe detail men should be aware of about their industry and which they can point to with pride is the prodigious feat of turning out millions of doses of Salk vaccine in record time—then voluntarily reducing the price to less than half its original level. Or when Asian influenza threatened, how private industry tooled up to turn out the highly specialized vaccine, only to leave warehouses stocked with material whose therapeutic and market value was nil.

As John McKen, president of Charles Pfizer & Co., said in a recent speech, "When facts like these are impressed in public knowledge, people will be able to form a true image of pharmacy and the pharmaceutical industry as honest, hard-working, productive members of American society with a deep sense of integrity."

Now, let me cite a couple more facts which may be useful in this same argument:

—Health Information Foundation reports that

between 1932 and 1952, the length of stay in hospitals per patient decreased from 12.8 days to 9.8 days.

—The Department of Commerce last year said that drug expenditures constituted only a 16 per cent share of total medical expenditures, as contrasted to 23 per cent in 1942.

—The National Health Education Committee gives these figures for the declines in mortality rates between 1944 and 1954 for the following diseases. I'll add here on my own that this is the period since the introduction of modern chemotherapy:

Influenza .....	91%
Appendicitis .....	76%
Rheumatic Fever .....	73%
Syphilis .....	63%
Tuberculosis .....	73%
Pneumonia .....	43%
Nephritis .....	60%
Maternal deaths .....	77%
Infant deaths .....	33%

These are all striking advances in modern health and they are unique in America. They should be repeated time and again along with the fact that modern medical care in America is a modern wonder of the world. It is more dramatic than the launching of a hundred sputniks because it deals with the lives of humans rather than the death of dogs.

I have continuing combats with some of my acquaintances who think they pay too much for what they are getting in the health field. When someone tells me they believe they are paying exorbitant prices for 20 antibiotic capsules, when twenty years ago their doctor might have been compelled to send them to bed with an aspirin tablet, I just inform them that modern drugs are no more expensive today than television sets were twenty years ago. Of course, neither was available twenty years ago. This generally ends the argument.

You may well ask what all this has to do with detailing, and you would be right in asking.

What I've tried to do is point up a few pertinent elements of the business of maintaining a high standard of health at a bargain that can be used in persuasion with your professional contacts as detail men.

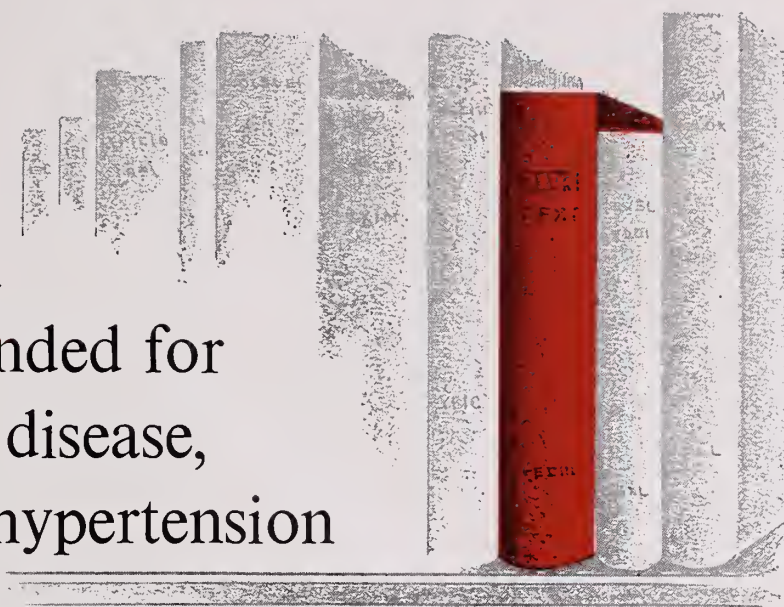
Many of you may have better points to put forth. If you have, please use them.

Many of you may have great loyalty to your own products or to your own company. However, it isn't good public relations to knock the competition.

This isn't a mud-smearing political campaign. It is the business of the health of human beings. When one company within the industry, or one segment of the health team is knocked or singled

*concluded on page 538*

text book  
recommended for  
coronary disease,  
essential hypertension



# THESODATE

A product or treatment must survive the test of clinical usefulness before it is admitted to the pages of authoritative text books.

Theobromine Sodium Acetate (often by its trade name Thesodate) is regularly included in standard text books for classical therapy of coronary heart disease, essential hypertension and for diuresis.\*

## THESODATE

The original enteric coated tablet of Theobromine Sodium Acetate.

### Supplied in flexible dosage forms:

Thesodate 0.5 Gm. (7½ gr.) or 0.25 Gm. (3¾ gr.)

Thesodate 0.5 Gm. (7½ gr.)

with phenobarbital 30 mg. (½ gr.)

or with phenobarbital 15 mg. (¼ gr.)

Thesodate 0.25 Gm. (3¾ gr.)

with phenobarbital 15 mg. (¼ gr.)

Thesodate 0.3 Gm. (5 gr.)

with potassium iodide 0.12 Gm. (2 gr.)

and phenobarbital 15 mg. (¼ gr.)

R.S. Thesodate 0.5 Gm. (7½ gr.)

with Rauwolfia Serpentina 50 mg. (¾ gr.)

\*Paul Dudley White, "Heart Disease" 1951 (Macmillan) page 480;  
William D. Straud, "Current Therapy," 1955 (W. B. Saunders) page 102;  
Cecil & Loeb's Textbook of Medicine, 1955 (W. B. Saunders) page 1,326;  
Wilson & Gisvold, "Textbook of Organic Medicinal and Pharmaceutical Chemistry," 1956 (Lippincott) page 262;  
Goodman & Gilman, "The Pharmacological Basis of Therapeutics," 1941 (The Macmillan Co.) page 281;  
Albrecht, "Modern Management in Clinical Medicine," 1946 (Williams & Wilkins) page 254;  
Friedberg, "Diseases of the Heart," 1956 (Saunders) page 285;  
Walter Modell, "Drugs of Choice," 1958-1959 (C. V. Mosby) pages 100, 475, 615.

*Brewer*  
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**Brewer & Company, Inc.** Worcester, Massachusetts





# NIAMID\*

the mood brightener

Lifts the  
burden of  
depression...  
opens the way  
for a sunnier  
outlook

## New areas of therapy

NIAMID is clinically effective in a broad range of depressive states, including: involuntional melancholia, senile depression, postpartum depression, reactive depression, the depressive stage of manic depressive disease, and schizophrenic depressive reaction.

A wide variety of psychoneurotic depressions seen in general practice also respond effectively to NIAMID. Depression associated with the menopause and with postoperative states, and depression accompanying chronic or incurable diseases such as gastrointestinal and cardiovascular disorders, arthritis, and inoperable cancer, can now be treated successfully with NIAMID.

NIAMID is also strikingly effective for many complaints, mild or severe, vague or well defined, whether due to masked depression rather than to organic disease. This masked depression may take the form of guilt feelings, crying spells or sadness, difficulty in concentration, loss of energy or drive, insomnia, emotional fatigue, feelings of hopelessness or helplessness, loss of interest in normal activity, listlessness, apprehension or agitation, and loss of appetite and weight.

While tranquilizers have had some measure of effectiveness in many of these areas, NIAMID now gives the practicing physician a new, safe drug for the specific treatment of depression without the risk of increasing the depressive symptoms.

## New safety

The outstanding safety of NIAMID in extensive clinical trials eliminates the hepatotoxic reactions observed with the first of the monoamine oxidase inhibitors. These reactions have not been seen with NIAMID.

Acute and chronic toxicity studies show this distinctive freedom from toxicity. Moreover, during the extensive clinical trials of NIAMID by a large number of investigators, not only has no liver damage been reported, but only in a very few isolated instances have hypotensive effects been seen.

The absence of toxicity may be the result of the unique carboxamide group in the NIAMID molecule. This structure may explain why NIAMID is excreted largely unchanged in the urine, with only insignificant quantities of potentially free hydrazine being formed. Previously, where a monoamine oxidase inhibitor had been associated with hepatic toxicity, there was some evidence that substantial quantities of free hydrazine were formed in the body.

## Background of NIAMID

A major advance in the treatment of mental depression came with a newer understanding of the influence of brain serotonin and norepinephrine on the mood. Levels of both these neuro-hormones are decreased in animals under experimental conditions analogous to depression; relief of these mood depressions is seen with a rise in the levels of both serotonin and norepinephrine.

A second advance came with the development of monoamine oxidase inhibitors, substances which raise the cerebral level of both serotonin and norepinephrine. The first of the amine oxidase inhibitors raised the cerebral level of serotonin, but did not appear to raise that of norepinephrine levels proportionately.

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Attention at Pfizer Research was then directed to a new drug that would overcome this disadvantage. NIAMID significantly raises the cerebral level of *both* serotonin and norepinephrine under experimental conditions.

The dramatic discovery of NIAMID now makes available an extremely effective, safe antidepressant for the successful treatment of a full range of depressive states.

## Precautions

Side effects are most often minor and mild manifestations of central nervous system stimulation, modifiable by reduction in dosage; these may take the form of restlessness, insomnia, headache, weakness, vertigo, dry mouth, and perspiration. Care should be taken when NIAMID is used with chlorothiazide compounds, since hypotensive effects have been noted in some patients receiving combined therapy—even though hypotension has rarely been noted with NIAMID alone. There has been no evidence of liver damage in patients on NIAMID; however, in patients who have any history of liver disease, the possibility of hepatic reactions should be kept in mind.

## Dosage and Administration

Start with 75 mg. daily in single or divided doses. After a week or more, revise the daily dosage upward or downward, depending upon the response and tolerance, in steps of one or one-half 25 mg. tablet. Once satisfactory response has been attained, the dosage of NIAMID may be reduced gradually to the maintenance level.

The therapeutic action of NIAMID is gradual, not immediate. Many patients respond within a few days, others satisfactorily in 7 to 14 days. Some patients, particularly chronically depressed or regressed psychotics, may need substantially higher dosages (as much as 200 mg. daily has been used) and prolonged administration before responses are achieved.

## Supply

NIAMID is available in: 25 mg., pink, scored tablets in bottles of 100; and 100 mg., orange, scored tablets in bottles of 100.

## References

Complete bibliography and Professional Information Booklet are available on request.

\*TRADEMARK FOR BRAND OF NIALAMIDE



**NIAMID**  
*the mood brightener*



# BUTLER HEALTH CENTER — FIRST FULL YEAR OF OPERATION

*continued from page 519*

Our research studies show that the day program is particularly applicable where patients need more support, socialization or control than out-patient treatment offers, but do not require full twenty-four-hour hospitalization.

Both out-patient and day care can provide a gradual introduction to residential treatment for those patients reluctant to enter the hospital. On day care they can overcome their fear, become acquainted with us and we can wait for the patient to see for himself what advantages lie in full-time hospitalization. For many the anticipated residential treatment proves unnecessary.

Where residential treatment reinforces the patient's illness by increasing feelings of hopelessness, helplessness and incurability, or where it is liked too well by the dependent patient or becomes a lifetime sanctuary, the patient can find in the day program an opportunity to increase his confidence and self-esteem, and to overcome his denial of wellness. The family too can become impressed with the patient's ability rather than his disability.

The family can maintain its responsibility for the patient and engage constructively in the treatment program when the patient returns home each night.

The family has a respite from coping with the patient throughout the day and the patient from coping with them, but both can gain support and courage in working out their problems together during the rest of the day.

## *Residential Service (In-Patient)*

During 1958, the living accommodations for in-patients were redecorated and refurnished, making three compact integrated units; acute, convalescent, and geriatric. The furnishings converted the wide corridors into sitting rooms where patients could group in a congenial manner and have available to them books, games, television and handicraft supplies.

The nursing personnel, through experience and in-service training, developed into a smoothly functioning unit which provided individualized attention to each patient. Personnel consisted of eight psychiatric nurses, ten licensed practical nurses and fourteen attendant nurses. Co-operation between patients, nurses, and occupational therapy provided varied and entertaining evening and weekend programs as well as daytime activities.

Results of in-patient treatment for 1958 were as follows:

There were 150 different patients admitted for treatment during 1958, on whom final disposition had been made at the end of the year. The remainder of the patients admitted were for observation and temporary or custodial care only.

Of the 150 treatment cases, the following disposition was made:

Discharged to community recovered	39 (26%)
Discharged to community improved	93 (62%)
Discharged unimproved	9 (6%)
Transferred to other hospitals or nursing homes for further care and treatment	7 (5%)
Died	2 (1%)

A total of 141 of these 150 patients or 94% were discharged to the community.

A total of 132 or 88% were discharged to the community as recovered or improved.

Another indication of treatment results is that the duration of hospital stay averaged thirty-four days.

The service rendered by a private hospital is limited where patients do not have the financial resources for such hospitalization. The extent to which financial lack has made transfer of patients to a state hospital necessary is a matter of general concern.

With one debatable exception, no patient with an acute mental disorder was transferred to a state hospital because of financial limitation during 1958. This was made possible by the assistance of the United Fund, the Butler Beneficiary Funds, and

*continued on page 536*

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# BUTLER HEALTH CENTER — FIRST FULL YEAR OF OPERATION

*continued from page 534*

Federal Research support, which, together, made up the lack for those who could not afford full cost of hospitalization. Financial assistance was given to a total of 174 persons: 110 out-patients, 14 day patients, and 50 residential patients.

The increased proportion of cost paid by Blue Cross has benefited many others and made their hospitalization at Butler possible.

In the case of four patients with chronic, long-term disorders which required lengthy care, financial lack that could not be made up by endowment or other funds led to hospitalization in state hospitals.

Our research study is delineating the areas where residential treatment is indicated. Generally speaking, it is indicated for patients with psychoses and psychoneuroses during periods of crisis in which estrangement and alienation between patient and family reach a point where relationships become too destructive to continue any longer. At such times admission to the hospital is of crucial therapeutic value.

Abatement of the destructive feelings requires a living situation where we can manage more aspects of their lives, induce rest if rest is needed, stimulate activity where activity is needed, where we can deal with the family and help them with their disordered feelings, and where we can prescribe the amount of contact between patient and family.

Full-time hospitalization is often indicated where the patient is denying his illness or his relatives are denying his illness. Here the purpose is to permit patient and relatives to see that the patient is as ill as he really is. This is in contrast to the use of the day patient department for the opposite reason; that is, to let the patient who is cherishing his illness and denying his wellness see that he is as well as he is, and to let the family see that the patient is as well as he is.

There are many episodes of turmoil, panic, or

delirium where full twenty-four-hour a day care is needed for the duration of the acute episode but where out-patient or day care is more appropriate as soon as it is passed.

There are times when a person may need a sanctuary either from outside stress or to assist his own controls.

## *Special Intermediate Services*

The day service provides but one of the intermediate treatment opportunities between out-patient visits at one extreme and full-time hospitalization at the other.

Once we can overcome our institutionalized stereotype of seeing either full-time hospitalization or none at all, then a wide variety of valuable intermediate possibilities can be made available. Although we are just beginning to explore the advantages of these part-time hospital experiences, they are showing important possibilities and are going to increase.

*Part-time Hospitalization* can give the patient full hospital care and treatment for any determined part of the week as indicated. For one patient the period of Monday morning to Tuesday night and Thursday morning to Friday night was valuable; another is a regular in-patient but one day and night each week.

*Night Care* provides for those patients who can work, attend school or live at home during the day, but who require hospital care at night.

*Half-way House* is another partial hospitalization. This is useful for the patient who can benefit by living in the hospital and having the general association with patients and personnel and use of the activity areas, but who does not require full nursing and psychiatric care.

*Home Service* is another somewhat related intermediate service. The development of this has progressed throughout the year. Here we have the values involved in assisting the patient to remain in his own home. This assistance can consist either of visits to the home to help in crisis situations by nurse or social worker, or by placing nurses, licensed practical nurses, or attendant nurses in the home to offer care, companionship and support. Housekeepers are often particularly needed and such a service has been developed by our nursing department.

During 1958, there were twenty-seven home visits made to thirteen different patients by six different personnel, four by nurses, two by social workers. Housekeeping service was arranged for ten families.

Developments of this service are due to continue as we become better skilled in determining the indications for the service and in training personnel to provide it.

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### Adolescents

In recognition of the need for treatment of adolescents, the twelve- to eighteen-year-old group, Butler Health Center has admitted patients of this age group, fifty-nine to out-patient, nineteen day service, and eighteen in-patient facilities. A total of ninety-six adolescents received service here during 1958.

Our treatment team, throughout the year, has achieved greater confidence in their skill with this age group. A doctor, nurse and social worker have become particularly interested and adept in meeting their special needs. Work with the families of the adolescent has been found essential and has increased.

We are impressed with the way the adolescents fitted into our total program and benefited from their association with patients of all ages.

### Geriatrics

Last year we reported the demands on Butler to provide service for the older patients and the development of out-patient, day service, and temporary care programs for their use. There continued to be a constant demand for us to receive older patients for long-term care. In response to this, the upper floor of Goddard house was redecorated and opened on April 7, 1958, for this purpose.

Our experience during 1958 with these patients has been very gratifying, where we have seen the favorable results of thorough evaluation of the patient, of providing individualized care and treatment, of maintaining the patients' ties with the community.

### Research

Research progressed along functional lines, closely integrated with the service for which it was designed.

The project from the Society for the Investigation of Human Ecology further clarified personality, social situation and drug action assessment. This was immediately applicable to the understanding of everyday patient, family and ward assessments.

Study of the effectiveness of intensive treatment of the acute psychosis by utilizing flexibly a variety of services, namely out-patient, day care, and short-term in-patient service was provided by the United States Public Health Service project on Alternatives to Hospitalization. Findings led to the aforementioned discriminations as to the specific indications and values of each of these services. During the year, fifty-four patients who would conventionally have been hospitalized were provided effectively with alternative treatment. A further number who did require residential treatment had their

*concluded on next page*

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hospital stay substantially shortened through the effectiveness of alternatives to residential treatment, a situation long prevalent in medicine and surgery in general hospitals, but far newer in psychiatric facilities.

We are obtaining evidence of the importance of continuity in the relationship between doctor and patient, as it appears that the patients treated by our psychiatric associates, before, during, and after hospitalization are having a remarkable short stay (30 days). The same is true for the patients who were in treatment in our out-patient department and continued in treatment by the same physician during and after their hospitalization.

Two projects provided service and research evaluation of the treatment given to patients with chronic, long-term mental disorders. These were "Interaction of Personnel and Chronic Psychotics" and "Evaluation of Combined Physical and Mental Rehabilitation." Of twelve patients severely disabled for several years prior to treatment here, all but two have shown at least moderate improvement; seven of these have been discharged within one year of the time their treatment at Butler was begun. In ten cases, a work program contributed significantly to improvement. In seven cases, extensive and continuous work with the family was a critical factor. Psychotherapy and/or drugs were

important in several cases.

The work on rehabilitation done in conjunction with the State Division of Vocational Rehabilitation, facilitated by a grant from the Department of Health, Education and Welfare, is developing a model of Federal, State, and Private Agency collaboration. It provided assessment of 115 patients and a wide variety of five-day a week rehabilitation service for forty-nine patients, of whom 40% are currently employed. Here, as in the chronic interaction cases, the work program, group and/or individual psychotherapy, and social casework with families were the effective agents in re-engaging the patient in useful social and vocational life. In approximately 40% of the cases, the problem was that of combined physical and nervous disabilities and this program is providing a background of experience with this difficult group of cases.

### SUMMARY

The first full calendar year of operation of Butler Health Center is reported. As Butler Health Center is the only private (tax free) mental hospital serving Rhode Island, the accomplishments of this year have general medical interest.

Source, age, sex and diagnosis of patients admitted are given. The distinctive services of out-patient, day hospital and in-patient service are described. Figures on duration of hospital stay, treatments used and recovery results are presented.

A brief summary of the research projects is included.

### DETAILING IS ALSO PUBLIC RELATIONS

*concluded from page 530*

out for criticism, everyone else suffers.

I'd like to bring to your attention what public relations is. Public relations is the function of any group that evaluates public attitudes and identifies policies and procedures of any individual or group with the public interest and then executes activity to earn public understanding and acceptance. Each of you is a potential missionary or a potential public relations man as well as a professional service representative.

In your future contacts try to give some consideration to the answers you offer—back them up with facts where you can. You may find your own answers being repeated to you in time from people you least suspect to be on your side. The end effect may be that the public attitudes generally will be changed.

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## WOMAN'S AUXILIARY

### to the

## RHODE ISLAND MEDICAL SOCIETY

### ANNUAL REPORTS . . . 1958-59

#### ANNUAL REPORT OF THE SECRETARY WOMAN'S AUXILIARY TO THE RHODE ISLAND MEDICAL SOCIETY

**T**HERE HAVE BEEN three meetings during the past year.

The fall meeting was held October 8, 1958, at the White Horse Tavern, Newport, Rhode Island, with our Newport members acting as hostesses at a tea and social hour. Later a tour of the Breakers was enjoyed.

The midwinter dinner meeting was held January 1, 1959, in the Garden Room of the Providence Sheraton-Biltmore Hotel, with our husbands as guests. Mr. John Hanlon, sports writer for *THE JOURNAL-BULLETIN*, told of his recent trip to Russia, emphasizing sports in that country.

The thirteenth annual convention is being held today, May 13, 1959, at the Ledgemont Country Club, Seekonk, Massachusetts.

Eight meetings of the Executive Board and Committee Chairmen have been held and one meeting with the board acting as Finance Committee. Membership totals 508.

Proceedings of all meetings, reports and communications have been duly recorded and filed.

Respectfully submitted,

MRS. JAMES P. O'BRIEN

#### KENT COUNTY AUXILIARY

The Kent County Auxiliary held luncheon meetings in October, January and April; two at the Warwick Country Club, and the third at the Holland House in Warwick. Each was preceded by a board meeting.

Mrs. Caroline Breen, director of volunteer workers at the Kent County Memorial Hospital, explained the requirements and duties of teen-aged girls enrolled in the volunteer program being carried out at the hospital.

A "Silent Auction" was held in conjunction with our midwinter meeting, an affair which was not only enjoyable but brought additional revenue to our treasury. We were honored to have our state auxiliary president, Mrs. Stanley D. Simon, as our guest at this time.

The May meeting was highlighted by the show-

ing of slides and an informative talk by John G. Smith, Ed.D., Superintendent of the Doctor Joseph H. Ladd School in Exeter, Rhode Island.

In December of each year a Christmas party is given to the employees of the Kent County Memorial Hospital by the hospital staff and trustees, and once again our auxiliary members wrapped the gifts and decorated the hospital cafeteria attractively for the occasion.

Our membership has increased by three during the year, with a present total of 52. Attendance at the luncheon meetings is better than 50%.

Provision has now been made in our by-laws so that the wives of Rhode Island Medical Society members who reside in Warwick, as well as the wives of Kent County Medical Society members, may become active members of our county auxiliary.

We look forward to a much larger attendance during this coming year and becoming better acquainted with one another.

MRS. HAROLD L. COLLOM, *President*

#### PAWTUCKET DISTRICT AUXILIARY

Because of the enthusiasm of approximately forty women and the untiring efforts of Mrs. Mark Yessian, the Woman's Auxiliary to the Pawtucket Medical Association was organized on February 26, 1959.

The annual meeting with election of officers and adoption of constitution and by-laws was held on March 18, 1959.

Although we were late in organizing, I feel we have accomplished a great deal. Several new members have been added to the state auxiliary and one of our objects is already evident — "to promote friendly relations and mutual understanding among physicians' families."

As first president, I feel extremely honored and shall do all in my power to promote the objectives of both the state and county auxiliaries.

MRS. LOUIS E. HANNA, *President*

#### WOONSOCKET DISTRICT AUXILIARY

The fall and winter luncheon meetings were held at the Uxbridge Inn. They were very enjoyable and the attendance was gratifying.

The November dinner get-together with our



husbands at The Lochers in Milford was a tremendous success; everyone had a wonderful time.

George Kenny, chief public health educator for the state of Rhode Island, was guest speaker at the January meeting. Mr. Kenny's topic was *A Day in the Life of a Public Health Educator*. He said his job is to help people to understand and make use of the aids and the knowledge of doctors and scientists in order that citizens can lead healthier and more useful lives.

The next session, the biennial meeting, will be held April 28, at the Fireside, North Attleboro. Our guests will be Mrs. Stanley D. Simon, president, and Mrs. Mark A. Yessian, president-elect.

Close harmony and co-operation have made it a pleasure to work with all auxiliary members.

MRS. AURAY FONTAINE, *President*

### COMMITTEE REPORTS

#### *American Medical Education Foundation*

The Woman's Auxiliary to the Rhode Island Medical Society has contributed forty-five dollars to A.M.E.F. through the use of five *Sympathy* cards, two *In Appreciation* cards and two *A.M.E.F.* corsages. It was also voted to donate one hundred dollars to the Foundation, bringing our total contribution to one hundred forty-five dollars.

The opportunity for all to help the medical schools is presented through the use of these special cards—the *Sympathy* card, the *In Appreciation* card and a new card for general use. Attractive Christmas cards are also available. The membership is urged to take advantage of this fine twofold plan to raise money for the American Medical Education Foundation.

MRS. ROBERT V. LEWIS, *Chairman*

#### *Bulletin*

Forty-six subscriptions to the bulletin have been received for the year 1958-59. The bulletin serves as a guide for auxiliary members, also as a source of reference. It is useful in helping to co-ordinate local auxiliary activities with those of other states and also with auxiliary activities on a national scale. Each year more members become aware of its value.

MRS. CHARLES W. CASHMAN, JR.

#### *By-Laws*

Two proposals made by the By-Laws Committee have met with success in 1959. One is the addition to the constitution and by-laws of the auxiliary to the Rhode Island Medical Society. Under Dues—Section 7. That is: "Any new member joining and paying dues after September 1st, will not be billed until a year from January."

A recommendation was also forwarded to Mrs. Mason G. Lawson, national By-Laws chairman,

*continued on page 544*



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The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein.<sup>1</sup> Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,<sup>2</sup> in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy

64% of 42 pregnancies were salvaged by progesterone

83% of 73 pregnancies were salvaged by Delalutin

Eichner,<sup>3</sup> found that with Delalutin fetal salvage of infants below term weight (1000 to 2000 gm.) was significantly improved.

108 (76%) of 142 babies of this birth weight survived without progestational therapy.

16 (100%) of 16 babies of this birth weight survived with Delalutin therapy.

A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.<sup>4</sup> Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active", well-tolerated and long-acting.

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*Supply:* Delalutin is available in vials of 2 and 10 cc., each cc. containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

*References:* 1. Reifenstein, E. C., Jr.: *Annals N. Y. Acad. Sci.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. and Gyn.* 76:279, 1958.

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## WOMAN'S AUXILIARY REPORTS

*continued from page 541*

which has been acted upon favorably by that body. This is to allow the immediate past president of a state auxiliary to read her annual report (compiled by her and based on her year in office) if she so desires at the annual meeting after she goes out of office.

There has not been a Standing Committee but these members of the auxiliary attended the meeting at which two proposals were made: Mrs. Stanley D. Simon (president, Auxiliary Rhode Island Medical Society); past presidents, Mrs. Hannibal Hamlin, Mrs. Banice Feinberg, and Mrs. Herbert E. Harris; Mrs. Donald Larkin, treasurer; Mrs. Angelo Archetto, assistant treasurer, membership and Mrs. Francis L. McNelis, chairman.

MRS. FRANCIS L. MCNELIS, *Chairman*

*Civil Defense*

At the beginning of this year, Rhode Island Civil Defense Headquarters was contacted, extending the support of the Civil Defense Committee of the Woman's Auxiliary to the Rhode Island Medical Society. Its co-operation was offered in any project which they might desire to have it undertake and in case of any disaster or other emergency. No requests were made during the year.

Various Civil Defense materials were displayed to members of the auxiliary.

MRS. LEE SANNELLA, *Chairman*

*Historian*

Material of interest to members of the auxiliary—reports of committees, newsletters and pictures—have been filed in the *scrapbook* which will be kept at the Rhode Island Medical Society on Francis Street, where it will be available for reference at all times.

MRS. GUY E. WELLS, *Historian*

*Hospitality*

The Hospitality Committee performed its services for the auxiliary at the three open meetings for the year 1958-59. These functions are described elsewhere in these reports under the heading of *Program*.

Our hospitality committee took on two additional projects this year. The Woman's Auxiliary sponsored a hospitality room on September 27 and 28 for the American Academy of Cerebral Palsy with the Hospitality Committee in charge. It was a delightful experience meeting and chatting with doctors' wives from all over the United States.

For our annual dance in October, our hospitality committee converted itself into a telephone squad to remind members of this annual affair.

It has been a very enjoyable experience to serve as hospitality chairman, and I wish to thank the following members of my committee for their co-operation: Mrs. Etta Franklin; Mrs. Richard Haverly; Mrs. Ferdinand Forgiel; Mrs. Alphonse Cardi; Mrs. Arthur Hardy; and Mrs. Attilio Mangano.

MRS. D. RICHARD BARONIAN, *Chairman*

*Legislative*

The medical profession has always been concerned with protecting and prolonging life. In 1900, only 3,000,000 Americans were over age sixty-five. Today there are 15,000,000. Since its beginning, more than a century ago, the American Medical Association has been sincerely concerned with the medical aspects of caring for the aged. Today society as a whole and the medical profession as a group are seeking a financial solution to the demands of medical and hospital care.

The House of Delegates of the American Medical Association in December, 1958, urged all physicians in this country to adjust their charges for medical services to the economic circumstances of persons over sixty-five years of age with reduced incomes and very modest resources. This action looks forward to a creation of insurance and prepayment plans at lower rates for some older people. Medicine, backed by the banks and insurance corporations, can do a magnificent job of taking the lead in this field. Otherwise, legislation, humanitarian but financially disastrous, could be the alternative.

Physicians themselves as they eventually reach and join these millions over age sixty-five are still seeking a tax respite. The Keogh-Simpson bill has again been approved by the House Ways and Means Committee. Under provisions of this bill the self-employed, including doctors, would be permitted to set aside 10% of gross, adjusted income up to \$2,500.00 to be paid into retirement plans. The lifetime maximum total would be \$50,000. Income at age sixty-five would be optional, but mandatory at age seventy. The question now is whether this bill will be passed by the Senate in the 86th Congress now in session.

On February 18, 1959, a bill titled: Health Benefits for the Aged Under Social Security, the Forand Bill, was introduced in the House of Representatives. Its purpose is to amend the present Social Security Act. It offers to provide hospitalization, nursing home services, and surgical services for an individual who is receiving or is entitled to social security benefits, and his dependents. The cost of up to sixty days of hospitalization in any twelve-month period would be paid from the Federal Old-Age and Survivors' Trust Fund.

MRS. ARTHUR BRADSHAW, *Chairman*

*continued on page 546*



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**MEDICAL BUREAU**  
of the  
**Providence Medical Association**

## WOMAN'S AUXILIARY REPORTS

*continued from page 544**Newsletter*

This year saw the fulfillment of the dreams of numerous past chairmen, with the change in our *Newsletter* from the cumbersome mimeographed sheets, to a four-page printed form. This has enabled us to include a greater amount of material as well as pictures (two in each of our three issues), which we hope have interested our readers.

We are grateful to our officers and chairmen for their co-operation in sending their copy promptly, and to Mr. Farrell's secretaries at the Medical Library for addressing and stamping the *Newsletters*. Copies have been sent to the editors of the other forty-eight states, and we have received many samples from those states.

Our December edition was mailed to all doctors' wives in the state, in the hope that it would stimulate interest in the auxiliary.

Without the guidance and assistance of our president, Mrs. Simon, and our president-elect, Mrs. Yessian, your editor would have been lost in her first endeavor in publication.

MRS. H. BICKFORD LANG, *Editor*

*Scholarships for Nurses*

The two Lillian W. Harris scholarships for \$150.00 each will be awarded this year to two student nurses; one from Pawtucket Memorial Hospital, and one from Newport Hospital. Indirectly we have been able to assist two more student nurses obtain scholarships; one from Rhode Island Hospital, and one from St. Joseph's Hospital.

On March 7 of this year I covered the North Atlantic Council of State Leagues for Nursing Careers Conferences at Hope High School. This discussion was primarily to interest high school students in nursing and to help them select the type of education that is best for them; as well as how to interest graduate nurses in administrative, supervisory, and teaching positions, and to help them get the academic and professional experiences to prepare them for these positions. The North Atlantic Council of State Leagues for Nursing and the New England Exploratory Conference are working regionally to meet our needs.

For the girls who are interested, but financially unable to enter the nursing profession, they should contact their director of nursing, so that some measure may be taken to assist them. Although 800,000 men and women are engaged in the nursing profession today, there still aren't enough. You may help by encouraging young women through your P.T.A., auxiliaries, and church groups. Scholarships may be obtained through the Department of Education, Veterans' Auxiliary, and many clubs.

MRS. NATHANIEL D. ROBINSON, *Chairman*

*Parliamentarian*

Perhaps there is no one in this group more qualified to observe the progress and steady growth of the Woman's Auxiliary to the Rhode Island Medical Society than I as your parliamentarian.

Not because I am smarter or older than anyone else but because I have held office continuously since our organization in 1947—first as your president, then as your parliamentarian.

It has been a great pleasure and a great honor to serve in both capacities.

As I have met with the various presidents, executive committees and committee chairmen each year at board meetings, I have marveled at the ability of each group to carry on.

Each president, her faithful officers and committees with their various personalities have contributed to the growth of their auxiliary and although each group has been different, all have worked diligently to improve the quality of the Society.

Each group, and the present group is no exception, has succeeded in making the Woman's Auxiliary to the Rhode Island Medical Society a very worthwhile organization and one I am very happy to be a member of.

MRS. HERBERT E. HARRIS, *Chairman*

*Program*

The three meetings planned by the Program Committee during the year 1958-59 have been varied and, I hope, interesting to the members who attended.

On October 8, during the Interim Meeting of the Rhode Island Medical Society, our Newport members were hostesses to about thirty-five auxiliary members who met at the historic White Horse Tavern for a delicious tea, followed by a tour of the Breakers. Dinner with the men at the Viking Hotel completed the day. The success of this meeting was due to the efforts of our Newport members, to whom I am most grateful.

The midwinter meeting on January 21 was the first meeting to which our husbands had been invited, and from all reports, they want to come again. In spite of a last-minute departure for Cuba by our speaker and the hasty substitution of another, about one hundred and twenty members and their husbands spent a delightful evening in the Garden Restaurant of the Sheraton-Biltmore Hotel. The dinner was delicious and John Hanlon, sports writer for THE PROVIDENCE JOURNAL, entertained us with a fascinating account of his recent trip to Russia.

*Safety* will be the theme of the program on May 13, when the speaker will be Mr. Charles Shields, executive director of the Rhode Island Council on Highway Safety. Mr. Shields will demonstrate the alcometer by testing any willing victims. Mrs. Paul B. Rauchenbach, Eastern Regional vice-president

*continued on page 548*





# Half a Lifetime . . .

When you need medical attention, you want — and are entitled to — the best medical service possible. That means, of course, competent physicians.

Under the system which produces our American doctors, you can ask for and get the services of one of the most highly-trained men in the world. You can be sure of his ability — protected by extremely thorough courses of training and by standards for the profession set by law.

Your doctor, specialist or surgeon has spent nearly half his expected lifetime preparing for the medical profession. He has directed his efforts toward medicine alone — through a maze of preparation.

There's no short cut to becoming a physician. College, medical school, and internship — plus further study if he specializes — tremendous amounts of time and money must be spent before the State of Rhode Island finally grants his license.

More, today's doctor is a combination of skilled physician plus a human being who has learned how to apply his skills to caring for other human beings.

Today, under the care of your physician, you can be sure you're receiving medical and surgical care more advanced and complete than ever before.

It is the aim of Physicians Service to make that care available with increasing benefits to all the people of Rhode Island who ask for it.

*Better Health Care for More People Through*

# *Physicians Service*



## WOMAN'S AUXILIARY REPORTS

*continued from page 546*

of the National Auxiliary to the American Medical Association, will be our guest of honor and bring greetings from National, and Doctor Francis B. Sargent will bring greetings from the Rhode Island Medical Society.

It has been a pleasure to work with our president, Marion Simon, who has been a constant source of help and advice and I am also grateful to the members of the Program Committee, Mrs. William J. Butler, Mrs. Warren W. Francis and Mrs. Normand E. Gauvin.

MRS. JOHN T. BARRETT, *Chairman*

**Recruitment**

Our program for this year was twofold:

1. Recruiting applicants to enter the paramedical fields,
2. Awarding two scholarships of \$300.00 each to students in the fields of medical social work, and physiotherapy.

During the past year, the chairman was asked to review three films pertaining to paramedical careers.

The Physiotherapy Association is very anxious to have the co-operation of the auxiliary. There is a possibility that the association and the auxiliary will co-sponsor a film program and tea in the fall and thereby become better acquainted.

On March 7, at the North Atlantic Council of State Leagues for Nursing, the chairman and Mrs. Robinson represented the auxiliary. The emphasis was on the importance of the medical auxiliaries and the part they play in the recruitment programs throughout the country.

Our group is becoming well known and has had several requests to participate in the high schools' *Career Day*. In order to do our job well, however, we shall need many more qualified volunteer speakers from the membership.

The auxiliary and the Rhode Island Hospital

## RHODE ISLAND MEDICAL JOURNAL

Association have shared the cost in the purchase of the film, *Helping Hands for Julie*. This film is kept at the association office on Thayer Street, and is available to groups interested in promoting paramedical careers.

At present, we are in the process of organizing two future nurse clubs at Tolman and West High Schools in Pawtucket. We expect the clubs to be active in September.

Nursing—

MRS. ALEXANDER JAWORSKI, *Chairman*

Occupational Therapy—MRS. MICHAEL E. SCALA

Physio-Therapy—MRS. CHARLES CASHMAN

Medical Technician—MRS. CHARLES DOES

Medical Social Worker—

MRS. EDWARD DAMARJIAN

Dietitian—MRS. FRANCIS L. McNELIS

**Safety**

Although the Safety Committee did not present any special projects this year, we did attend meetings and offered our help to other organizations concerned with safety.

We attended the Governor's Conference on Highway Safety. At this conference, they discussed the driver education program. They also pointed out the need for making the public aware of traffic safety problems.

We were also asked to attend a meeting of the Lions Club who are planning a *Safety Day* on April 26. We extended our full co-operation and will assist them at that time by displaying in a store window, our posters depicting the hazards of drunken driving. We believe that this exhibit is excellent and are grateful for this opportunity to present it to the public.

At our annual meeting in May, we are going to have as guest speaker, Mr. Charles Shields, executive director of the Rhode Island Council on Highway Safety. He is going to demonstrate the alcometer machine which was previously shown to our committee at a Fall meeting of the Rhode Island Council on Highway Safety. It was a very interesting performance.

I regret that we were unable to present a few special projects on safety, but the opportunity did not arise. Yet, we tried to keep members informed on safety problems and will continue to do so in the future.

MRS. SUMNER RAPHAEL, *Chairman*

**Today's Health**

Our principal aim this year was to increase sales of TODAY'S HEALTH and to inform the public of its new format.

We began our attempts by selling subscriptions last May, at the annual meeting of the Rhode Island Medical Society. Posters were used for display

*concluded on page 551*

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## CONSTRUCTION PROGRAM FOR MEDICAL, DENTAL, AND PUBLIC HEALTH SCHOOLS\*

As Proposed by Congressman John E. Fogarty  
of Rhode Island to the Congress

**M**R. FOGARTY. Mr. Speaker, the cold, hard fact of the matter is that we as a nation are not doing what we should today to make sure that the schools of medicine, dentistry, public health, and other centers for education and research in the health field are adequate to meet the challenges and responsibilities they face, and all of us face, tomorrow.

One hears a great deal about progress in the health field these days. It is true that we have made giant strides in some vitally important areas. We can be proud of what has been accomplished in the construction of hospital and other health facilities, in the improvements of medical and public health services, in medical research and the assurance of its future development. We can be pleased with the advances associated with the pharmaceutical and chemical industry, with the contributions of voluntary health agencies and foundations, and with the health-consciousness of the American people which finds expression in organization and action. We can be proud of these things, and pleased, but we cannot be content.

One of the great gaps in our present programs is in the absence of broad support for the health institutions as institutions, as contrasted with the support of some of their separate functions.

Specifically, I am concerned that we are at the breaking point in terms of the ability of these teaching institutions in the health field to keep up with our population growth and with the demands engendered by the rapid changes in medicine and public health.

This is not a new concern of mine, or of many people who are influential leaders in medicine and science today. A great many proposals have been made by Members of Congress, by the executive branch, and by interests outside of the Federal Government seeking ways to meet at least part of the all too evident need. There has been a great deal of discussion, but almost nothing in the way of action.

The legislation that I introduce today proposes that the Federal Government give greater assistance in the renovation and modernization of our present medical and related schools, and that at the same

time we give encouragement and stimulus to the construction of new schools. It would build upon and extend the highly productive present program of matching grants to assist in the construction of health research facilities. Thus it sets no precedents and poses no philosophical problems, even among those who persist in the archaic belief that the use of Federal funds for the partial support of medical school activities is ipso facto a threat of Federal control and socialized medicine.

The thing my proposed legislation does is to give clear recognition to three things: First, that research and education are inseparable and often indistinguishable one from the other in a medical school environment; second, that adequate facilities are a basic requirement for medical, dental, and related research and education; and third, that the Federal Government shares in this responsibility to see that such facilities are provided commensurate with the national need.

In other construction programs, matching funds from Federal sources—such as the Hill-Burton hospital construction program and the health research facilities construction program—have been successful beyond all expectation in helping the States, communities, and institutions raise money from non-Federal sources. Such matching grants foster and encourage the putting of private and State money to effective use. Without such stimulus, the other funds might never be raised and the needed facilities might never be built.

It is proposed, therefore, that the Congress enact legislation which will modify and extend the Health Research Facilities Act, now in its third year and being very effectively administered by the Public Health Service, in the following major respects:

First. Changes the title of the Act to include facilities for education as well as research in the health field.

Second. Extend the authorized duration of the program to 5 years, beginning with the fiscal year 1960.

Third. Increase the annual authorized availability of funds from the \$30 million now provided for research facilities only to a total of \$50 million annually for both research and educational facilities.

*continued on next page*

\*Reprinted from the CONGRESSIONAL RECORD—APPENDIX, May 7, 1959 issue, page A3863.



ties, thus making \$250 million available for presently established schools of medicine, dentistry, public health, and osteopathy over a 5-year period.

Fourth. In addition, provides \$100 million with more favorable matching terms for the construction of new schools in the above fields, including an initial or starting grant of up to \$25,000 for planning purposes.

Fifth. Expands by 50 percent the membership of the Council that reviews and makes final recommendations on these grants to include educational as well as research representation.

There is great urgency associated with the enactment of such legislation.

One reason lies in the population changes that will occur during the next decade. Our total population will grow from 175 million to 220 million by 1970. Nearly three-quarters of this increase will be among persons over 65 and under 20 years of age, when requirements for medical care—which means, primarily, more physicians—are most frequent.

Moreover, medical practice continues to be more complex and the task of educating physicians correspondingly so. It is a task that cannot be carried out effectively in the absence of a fully adequate physical plant.

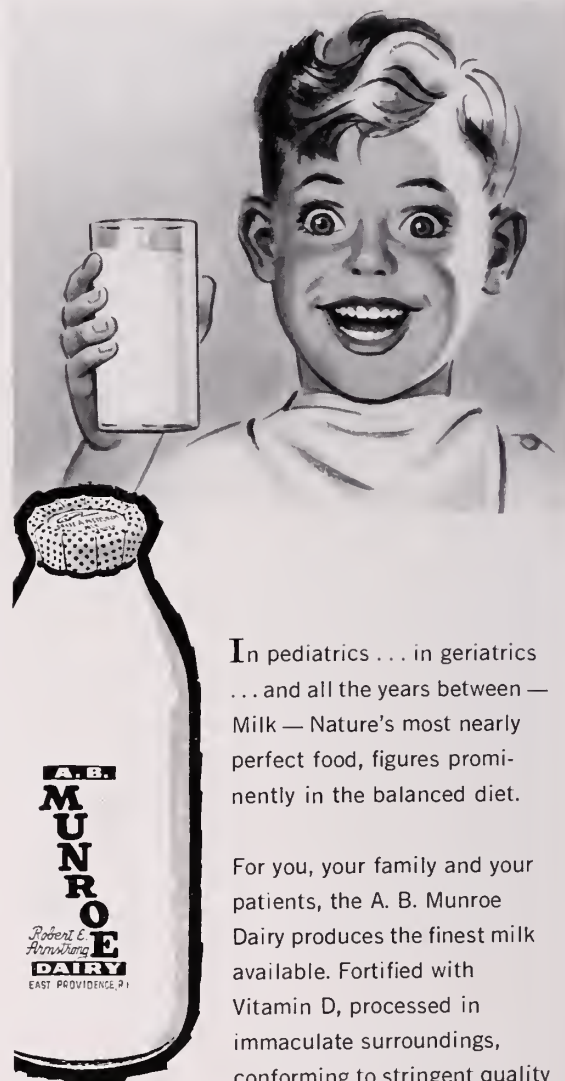
Then, too, medical and related schools carry an increasing responsibility to pioneer in the provision of medical and community health services. They carry out the largest component of the Nation's research in the health field. And they produce an increasingly important segment of the Nation's total manpower for research in the health sciences.

For these and a host of other reasons that are self-evident, it is abundantly clear that these schools are a national resource. Their ability to meet the challenges of tomorrow is a matter of deep public concern. It is our responsibility to give voice and substance to that concern in a program of action—a program that will reflect the public interest.

The medical schools' need for assistance in the construction of new and the renovation of existing facilities has been amply demonstrated and often reiterated in studies and reports by such eminent groups as the Association of American Medical Colleges, the Council on Medical Education of the American Medical Association, the Committee of Consultants to the Secretary of Health, Education, and Welfare, this House itself, and others whose interest, insight, and objectivity are beyond question. They do not pretend, nor do I, that matching grants for construction purposes will meet all of the future needs of the medical schools. Ultimately, of course, some way must be found to meet the needs of such institutions for general operating funds. The institutions themselves, the Congress, and the people are not able to see this issue clearly today. It will take time, and study, and debate for the issue

*concluded on next page*

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WOMAN'S AUXILIARY REPORTS

*concluded from page 548*

purposes and there were individual solicitations by members of the committee.

During the year, subscriptions were sold at every meeting of the auxiliary and an effort was made to emphasize the need of TODAY'S HEALTH, not only in the doctor's office, but in other areas—the non-professional home, beauty shops, schools, libraries, etc.

Reminders were routinely sent to those subscribers requiring renewal of TODAY'S HEALTH.

An article was written for publication in the *Newsletter* of the Woman's Auxiliary to the Rhode Island Medical Society. Also, advertisements or reminders were publicized in each edition.

Despite our efforts to sell more subscriptions, our sales have increased from thirteen last year to only forty-three this year. We were commended by Mrs. John M. Chenault, national TODAY'S HEALTH chairman for our good work, but were disappointed that we reached only 8% of our national quota.

The recommendations listed below are submitted for the following year:

1. Select a representative from each of our auxiliaries in the state: Kent County, Newport, Pawtucket, and Woonsocket—who will be directly responsible for sales in their respective area. Only a few subscriptions have been received from Woonsocket and Pawtucket. None from the other auxiliaries.

2. Continue the advertisements in the *Newsletter* of the Woman's Auxiliary to the Rhode Island Medical Society. Also include chairman's name and address and cost of subscription.

3. In the fall, preferably, a letter from the president or TODAY'S HEALTH chairman, should be sent to all members of the auxiliary requesting them to buy at least one subscription to TODAY'S HEALTH.

4. Advertise in the RHODE ISLAND MEDICAL JOURNAL.

MRS. MICHAEL E. SCALA, *Chairman*

Community Service

During the past few months, we have done a survey to determine how many volunteer hours are spent by individual members in outside activities such as scouting, P.T.A., and League of Women Voters. The response to this twice repeated survey was small but on the basis of those responses we did receive, it was determined that an individual member of the auxiliary was giving an average of twenty-five volunteer hours a month to organizations, other than the medical auxiliary.

MRS. HERBERT FANGER, *Chairman*

Mental Health

We were encouraged at the beginning of this year to use our membership in other organizations to further spread the idea of good mental health. With this in mind, programs were planned by our committee on juvenile problems and on better education.

Since the problem of high school marriage has become so acute, National Headquarters would like *Milestones to Marriage* distributed to as many high school seniors as possible. These have been ordered and will be sent out as soon as possible.

The auxiliary program at Charles V. Chapin Hospital is under way and two members of our auxiliary will start on Tuesday, May 12.

MRS. E. ALLAN CASEY, *Chairman*

Ways and Means

Our annual fund raising and dinner dance was held Saturday evening, October 18, at the Metacommet Country Club. The sum of \$1,031 was realized as profit and has been allocated to the Doctors' Benevolence Fund, AMEF, Paramedical Careers Scholarships and Nurses' Scholarships.

As chairman of this committee I have tried to impress the members with the fact this is our only money raising project and should be supported by all.

Again, thank you to a most enthusiastic committee and to all who contributed to make our sixth annual dinner dance a social and financial success.

MRS. LOUIS E. HANNA, *Chairman*

CONSTRUCTION PROGRAM FOR MEDICAL, DENTAL AND PUBLIC HEALTH SCHOOLS

*concluded from preceding page*

to be clarified, and it must be clarified before it can be resolved. We do know, however, that the health institutions of today are inadequately housed and that we will need additional institutions in years to come. Let us, then, move ahead one step further in our national effort to maintain and protect one of our most precious national resources, our health, by making it possible for the physical plants of the schools to be more adequate for tomorrow's needs.

Check the Date Now

Wednesday, September 23

Interim Meeting at Quonset



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Intrinsic Factor Concentrate . . . . .	5 mg.
Thiamine Mononitrate (B <sub>1</sub> ) . . . . .	5 mg.
Riboflavin (B <sub>2</sub> ) . . . . .	15 mg.
Niacinamide . . . . .	1 mg.
Folic Acid . . . . .	0.5 mg.
Pyridoxine HCl (B <sub>6</sub> ) . . . . .	5 mg.
Ca Pantothenate . . . . .	50 mg.
Choline Bitartrate . . . . .	50 mg.
Inositol . . . . .	50 mg.
Ascorbic Acid (C) . . . . .	10 I.U.
Vitamin E (as tocopheryl acetates) . . . . .	25 mg.
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Rutin . . . . .	30 mg.
Ferrous Fumarate . . . . .	10 mg.
Iron (as Fumarate) . . . . .	0.1 mg.
Iodine (as KI) . . . . .	157 mg.
Calcium (as CaHPO <sub>4</sub> ) . . . . .	122 mg.
Phosphorus (as CaHPO <sub>4</sub> ) . . . . .	0.1 mg.
Boron (as Na <sub>2</sub> B <sub>4</sub> O <sub>7</sub> ·10H <sub>2</sub> O) . . . . .	1 mg.
Copper (as CuO) . . . . .	0.1 mg.
Fluorine (as CaF <sub>2</sub> ) . . . . .	1 mg.
Manganese (as MnO <sub>2</sub> ) . . . . .	1 mg.
Magnesium (as MgO) . . . . .	5 mg.
Potassium (as K <sub>2</sub> SO <sub>4</sub> ) . . . . .	0.5 mg.
Zinc (as ZnO) . . . . .	

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## DATES YOU SHOULD CHECK

(Mark your calendar now for the dates applicable to you)

*Monday, September 14*

Meeting of the Council. Hope Club, Providence.

*Wednesday, September 16, and Thursday, September 17*

Conference on Aging for Representatives of the Medical Societies of New England, at Boston.

*Wednesday, September 23*

Interim Meeting of the Rhode Island Medical Society, at the Quonset Naval Air Station, 3:00 P.M.—9:30 P.M.

*Monday, September 28, to Friday, October 2*

College of Surgeons, meeting at Atlantic City, New Jersey.

*Monday, October 5*

Providence Medical Association Meeting. 8:30 P.M.

*Wednesday, October 7*

House of Delegates meeting. Rhode Island Medical Society. 8:00 P.M.

*Wednesday, October 14*

Doctor Isaac Gerber Oration. Miriam Hospital, 8:30 P.M.

*Friday, October 16, and Saturday, October 17*

New England Surgical Society, at Wentworth-by-the-Sea, New Hampshire.

*Saturday, October 17*

Dance. Woman's Auxiliary to Rhode Island Medical Society, Metacomet Country Club.

*Friday, October 23, and Saturday, October 24*

College of Physicians. Northeast and Eastern Canada Regional Meeting, at Providence (Sheraton-Biltmore Hotel).

*Friday, October 30 and Saturday, October 31*

New England Regional meeting, Medical Librarians, at Providence.

*Monday, November 2*

Providence Medical Association meeting. 8:30 P.M.

*Tuesday, November 3, to Thursday, November 5*

New England Postgraduate Assembly. To be held at Boston.

*Wednesday, November 11*

Armistice Day.

*Wednesday, November 18*

Kenney Clinic Day. Pawtucket Memorial Hospital.

*Monday, December 7*

Providence Medical Association meeting. 8:30 P.M.

*Tuesday, December 8, to Friday, December 11*

A.M.A. Clinical Session, at Dallas, Texas.

*Monday, January 4, 1960*

Annual meeting. Providence Medical Association. 8:30 P.M.



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# RHODE ISLAND



SEPTEMBER, 1959

## *Medical Journal*

*The Dr. Albert H. Miller Issue*

*Volume XLII, No. 9*

*Table of Contents, page 571*

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W. H. Rett, C. D., Jr., et al.: J.A.M.A. 167:1103, 1958;  
Am. J. Pub. Health 49:644, 1959.

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opens the way  
for a sunnier  
outlook**

## **New areas of therapy**

NIAMID is clinically effective in a broad range of depressive states, including: involuntal melancholia, senile depression, postpartum depression, reactive depression, the depressive stage of manic depressive disease, and schizophrenic depression.

A wide variety of psychoneurotic depressions, in general practice also respond effectively to NIAMID. Depression associated with the menopause and with postoperative states, and depression accompanying chronic or incurable diseases such as gastrointestinal and cardiovascular disorders, arthritis, and inoperable cancer, can now be treated successfully with NIAMID.

NIAMID is also strikingly effective for many of the "masked" depressions, mild or severe, vague or well defined, which are due to masked depression rather than to organic disease. This masked depression may take the form of guilt feelings, crying spells or sadness, difficulty in concentration, loss of energy or drive, insomnia, emotional fatigue, feelings of hopelessness or helplessness, loss of interest in normal activity, listlessness, apprehension or agitation, and loss of appetite and weight.

While tranquilizers have had some measure of effectiveness in many of these areas, NIAMID gives the practicing physician a new, safe drug, the specific treatment of depression without risk of increasing the depressive symptoms.

## **New safety**

NIAMID, in extensive clinical trials, has not been associated with the hepatotoxic reactions observed with the first of the monoamine oxidase inhibitors. These reactions have not been seen with NIAMID.


Acute and chronic toxicity studies show this drug to give complete freedom from toxicity. Moreover, during the extensive clinical trials of NIAMID by a large number of investigators, not only has no liver damage been reported, but only in a very few isolated instances have hypotensive effects been seen.

The absence of toxicity may be the result of the unique carboxamide group in the NIAMID molecule. This structure may explain why NIAMID is excreted largely unchanged in the urine, with only insignificant quantities of potentially free hydrazine being formed. Previously, where a monoamine oxidase inhibitor had been associated with hepatic toxicity, there was some evidence that substantial quantities of free hydrazine were formed in the body.

## **Background of NIAMID**

A major advance in the treatment of mental depression came with a newer understanding of the influence of brain serotonin and norepinephrine on the mood. Levels of both these neuro-hormones are decreased in animals under experimental conditions analogous to depression; relief of these depressions is seen with a rise in the levels of serotonin and norepinephrine.

A second advance came with the development of monoamine oxidase inhibitors, substances which raise the cerebral level of both serotonin and norepinephrine. The first of the amine oxidase inhibitors raised the cerebral level of serotonin, but did not appear to raise that of norepinephrine proportionately.

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Attention at Pfizer Research was then directed to a new drug that would overcome this disadvantage. NIAMID significantly raises the cerebral level of *both* serotonin and norepinephrine under experimental conditions.

The dramatic discovery of NIAMID now makes available an extremely effective, safe antidepressant for the successful treatment of a full range of depressive states.

## Precautions

Side effects are most often minor and mild manifestations of central nervous system stimulation, modifiable by reduction in dosage; these may take the form of restlessness, insomnia, headache, weakness, vertigo, dry mouth, and perspiration. Care should be taken when NIAMID is used with chlorothiazide compounds, since hypotensive effects have been noted in some patients receiving combined therapy—even though hypotension has rarely been noted with NIAMID alone. There has been no evidence of liver damage in patients on NIAMID; however, in patients who have any history of liver disease, the possibility of hepatic reactions should be kept in mind.

## Dosage and Administration

Start with 75 mg. daily in single or divided doses. After a week or more, revise the daily dosage upward or downward, depending upon the response and tolerance, in steps of one or one-half 25 mg. tablet. Once satisfactory response has been attained, the dosage of NIAMID may be reduced gradually to the maintenance level.

The therapeutic action of NIAMID is gradual, not immediate. Many patients respond within a few days, others satisfactorily in 7 to 14 days. Some patients, particularly chronically depressed or regressed psychotics, may need substantially higher dosages (as much as 200 mg. daily has been used) and prolonged administration before responses are achieved.

## Supply

NIAMID is available in: 25 mg., pink, scored tablets in bottles of 100; and 100 mg., orange, scored tablets in bottles of 100.

## References

Complete bibliography and Professional Information Booklet are available on request.

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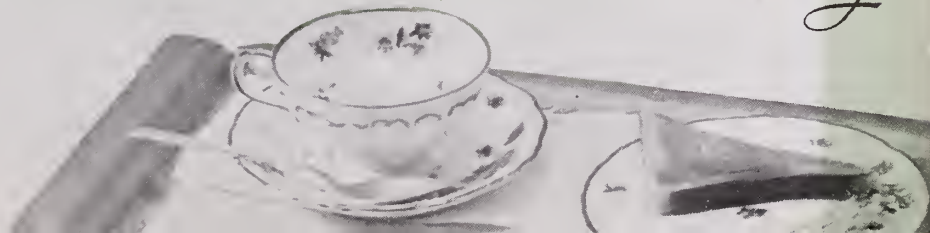
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1. Kety, S. S.: A medical regimen for benign rectal disorders, *GP* 10:75, Nov., 1954.

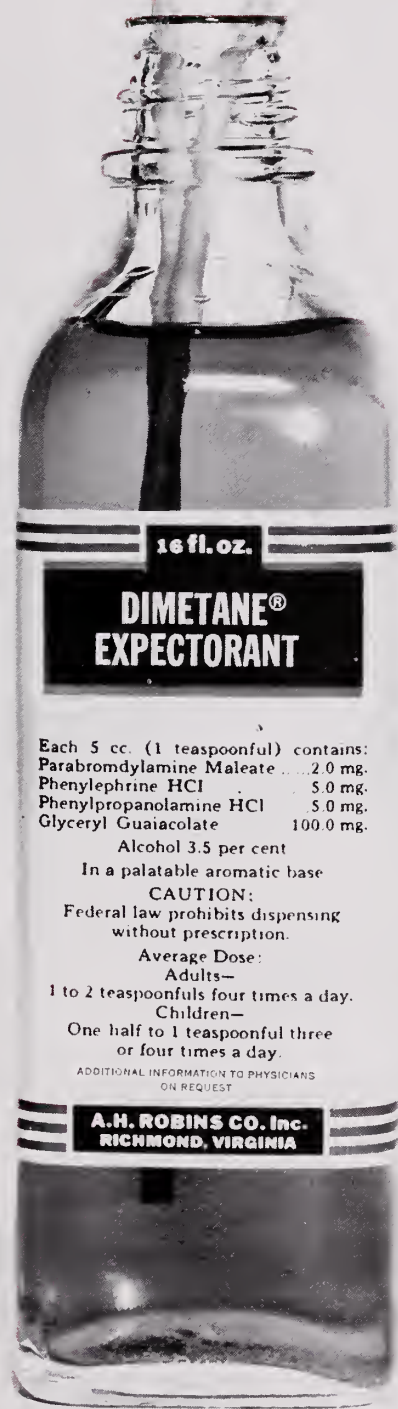
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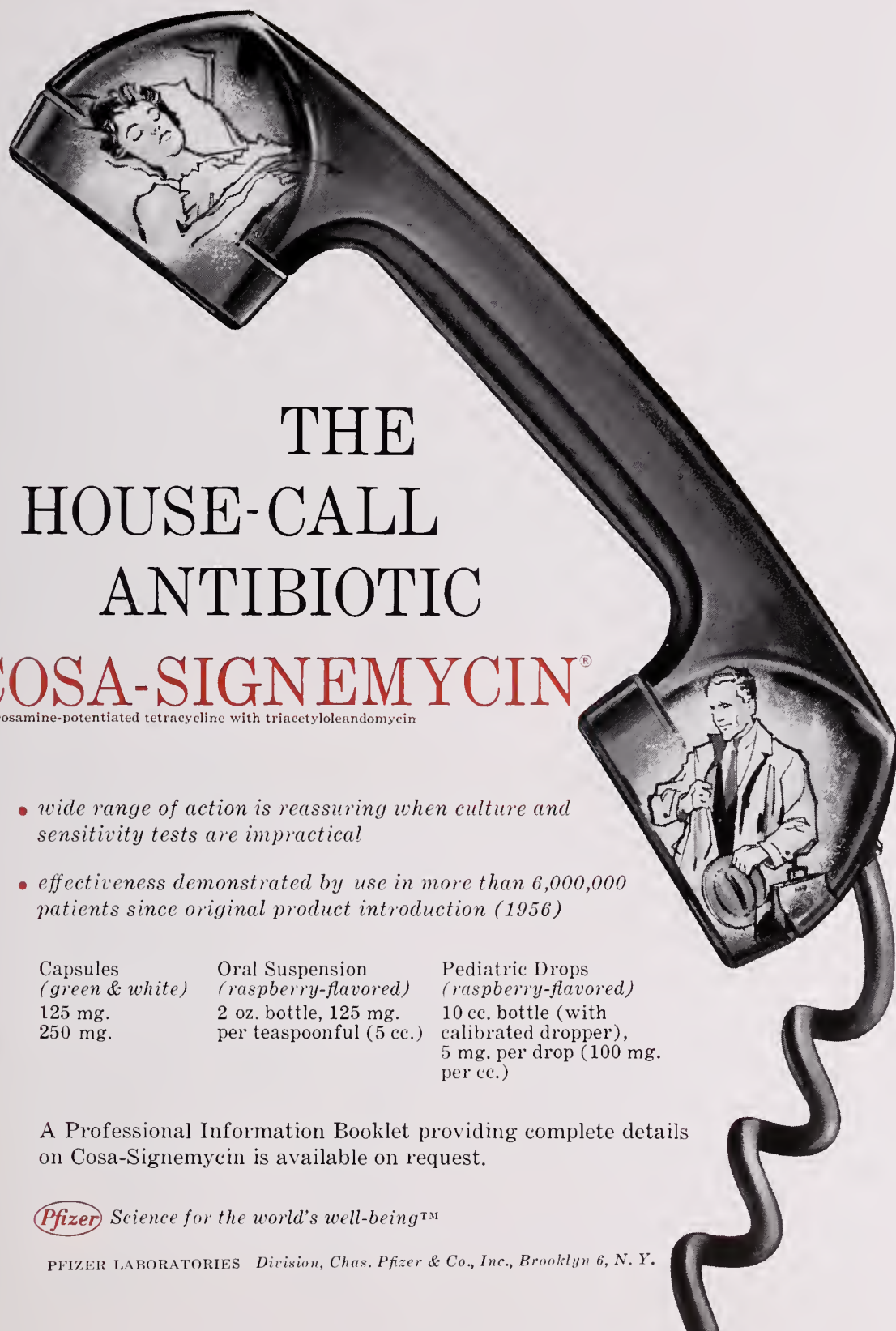
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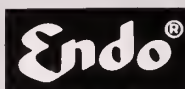
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Literature  
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\*1. Borrus, J. C.: J.A.M.A. 157:159, April 30, 1955. 2. Sellin, S.: J.A.M.A. 157:1594, April 30, 1955. 3. Lemere, F.: Northwest Med. 49:8, Oct. 1958. 4. Benda, B. and Locutti, C.: Lav. neuro-psichiat. 18:693, 1957. 5. Sellin, S.: J. Clin. Exper. Psych. 17:7, March 1956. 6. Berglund, M., Blumenthal, B., and Mordh, P.: Svenska läk. 53:3362, Dec. 1956. 7. Sel, H. A., Wood, J. A., and Dixon, H. H.: New York Acad. Sci. 67:780, May 9, 1957. 8. Hollister, L. S., Elkins, H., Miller, E. G., and St. Pierre, J.: Ann. New York Acad. Sci. 67:789, May 9, 1957. 9. Gass, J.: Russ. med. 34:233, July-Aug. 1957. 10. Li, R. et al.: J. Pediat. Exis 20:27, 1957. 11. Wiklund, P.: Anaesthesist 7, Aug. 1957. 12. Tucker, W. I.: South. J. 50:1111, Sept. 1957. 13. Roland, J.: Attual. ostet. 3(6), 9, Nov.-Dec. 1957. 14. Becker, W.: Klin. Mon. 1. Augen. 11:221, 1958. 15. Nebianco, G. and Cerani, T.: Oto-rhino-laring. ital. 26(2):143, 1958. 16. Lanza, G.: Minerva 19:1914, 1958. 17. Russo, R. and Gatti, F.: Act. Neurol. 3(1):36, 1958. 18. R. Gazz. med. ital. 3:149, Feb. 1958. 19. Kastur, R.: J. Indian M. Prof. 13, Feb. 1958. 20. St. Therap. 97:66, Feb. 1958. 21. B. P.: Lyon méd. 1958, March 2, 1958. 22.iglia, G.: Mine. 10:213, March 1958. 23. Glander, H. S.: Cardiol. 1:393, March 1958. 24. McClure, Arch. Ped. 73:101, March 1958. 25. Sprauer, V.: Internat. Rec. Med. CP Clinics 171:7, 1958. 26. Minson, R. Robinson, H. M.: South. M. J. 51:1, April 1958. 27. S. and P. L.: N. 52:1235, April 15, 1958. 28. Bouquerel, J., Naviau and: Ann. méd. Psychol. 11, 1958. 29. Rehou, R., Rehou, M. and Dorgeuille, C.: Maroc 17:784, July 1958. 30. Lyon méd. 200:288, Nov. 1958. 31. Lamphier, T. A.: Maryland 7:627, Nov. 1958. 32. Leue Med. Klin. 53:2113, Dec. 1958.

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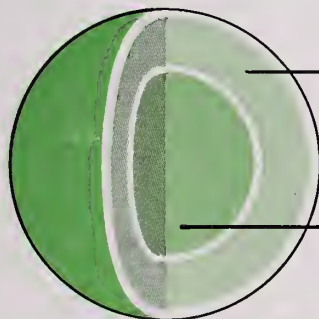




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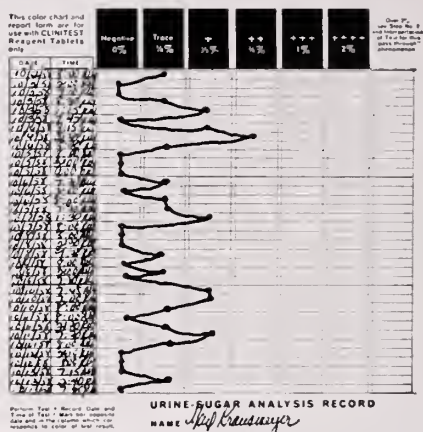
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Blood sugar levels. In renal glycosuria they are normal; in untreated diabetes, fasting blood sugars are usually 130 mg.% or over and postprandial levels 170 mg.%, or more.

Source: Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: The Treatment of Diabetes Mellitus, ed. 9, Philadelphia, Lea & Febiger, 1952, pp. 701-702.

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<sup>\*</sup>GP 16:121 (August) 1957.

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Patient M.S., 81, at the time of the first visit was in severe pain and very uncomfortable. Complained of swelling of wrists, legs and various joints; pain and stiffness in cervical area and lower spine; pain, swelling and limited motion in the fingers; slight ulnar deviation of the hand. M.S. demonstrates position necessary to put on his hat (motion was so restricted that he could not comb his hair).

Treatment and Result: After 36 hours of GAMMACORTEN therapy, M.S. had "complete relief." Joint swelling had decreased, pain was almost absent, range of motion had increased dramatically. At the end of the first week of GAMMACORTEN he was free of discomfort and able to return to his job as a porter. M.S. could put on his hat normally, could comb hair; joint function near-normal after first week.

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(dexamethasone CIBA)

- potent, effective corticosteroid
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C I B A

SUMMIT, N. J.



## THE WASHINGTON SCENE

### (A Summary Prepared by the Washington Office of the American Medical Association)

THE HOUSE Ways and Means Committee has put aside until next year the so-called Forand bill which is opposed vigorously by the medical profession.

But supporters of the legislation have made clear that they will press for action by Congress next year when politics will be paramount because of the presidential and Congressional elections in November.

The Ways and Means Committee took no action on the legislation after five days of hearings highlighted by the Eisenhower Administration lining up with the medical profession in opposition to it.

Arthur S. Flemming, secretary of Health, Education and Welfare, told the committee that "it would be very unwise" to enact such a bill. He warned of "far-reaching and irrevocable consequences." It would freeze health coverage of the aged "in a vast and uniform government system" and would mark the beginning of the end of voluntary health insurance for old persons, he said.

Secretary Flemming later promised to report to Congress early next year on possible alternatives, including Federal subsidies to private carriers of health insurance for the aged. But he took no position on any of the alternatives for the time being.

Summing up the hearings, Doctor F. J. L. Blasingame, executive vice president of the A.M.A., said:

"It was shown that it would be most unfortunate for the federal government to move in for political reasons and attempt in a compulsory fashion to solve by legislation problems which are being thoughtfully considered at the state and local level by the medical profession and other dedicated members of the health team."

Main support for the bill, which was sponsored by Rep. Aime J. Forand (D., R.I.), comes from organized labor. The legislation would increase federal Social Security taxes to finance hospital, surgical and nursing home care for Social Security beneficiaries.

Although this bill has been shelved for the time being by the House Committee, the problems of the aged are being studied by a Senate Subcommittee headed by Sen. Pat McNamara (D., Mich.). The Subcommittee on Problems of the Aged and Aging of the Senate Committee on Labor and Public Wel-

fare has held public hearings intermittently in Washington. It also planned to hold hearings in various other cities.

In his second appearance before the Senate Subcommittee, Doctor Frederick C. Swartz, chairman of the A.M.A.'s Committee on Aging, reported that state and local medical associations "have moved promptly" to make the A.M.A.'s six-point "positive health program" for the aged "an effective and workable instrument."

Doctor Swartz said that the problem of financing health services for the aged is "a temporary, not a permanent one" because "each year, more and more of the Americans who are reaching 65 are covered" by voluntary insurance.

\* \* \*

Democrats in Congress cut back their housing program further after President Eisenhower vetoed a \$1.4 billion bill. Starting with a \$2.1 billion program, Democrats came down to the \$1.4 billion figure in an effort to avoid a veto although it was a more expensive program than Mr. Eisenhower wanted.

After the President vetoed this bill anyway, Democrats came up with a \$1 billion bill which retained three provisions of interest to the medical profession.

They would:

- 1) provide construction loan guarantees by the Federal Housing Administration of up to 75 per cent of the cost of proprietary nursing homes;
- 2) authorize \$25 million in direct loans for construction of housing for interns and nurses, and
- 3) authorize a \$50 million revolving fund for direct loans to help private nonprofit corporations build rental housing for the elderly.

\* \* \*

Congress voted a compromise \$400 million appropriation for medical research. The amount was about \$80 million less than approved by the Senate, but was more than \$100 million above the Eisenhower Administration's request for the National Institutes of Health.

The allotments for research in specific fields included: cancer, \$91 million; mental health, \$68 million; heart, \$62 million; arthritis, \$47 million; neurology, \$41 million; allergy, \$34 million.

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September, 1959

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Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.<sup>1-10</sup> Studies performed in conjunction with gastrectomy<sup>4, 5</sup> and gastroscopy<sup>2</sup> have shown insoluble aspirin particles firmly adherent to

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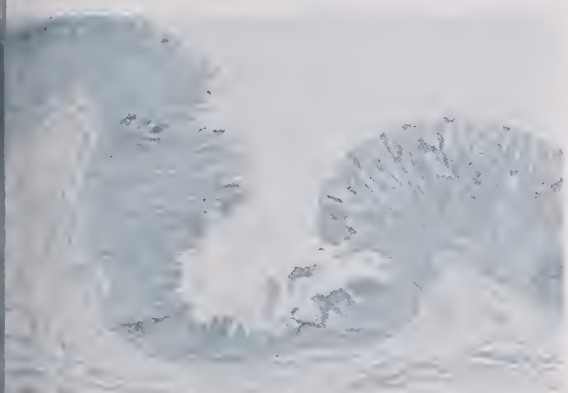


Calurin crystals in solution one minute after being mixed into water.

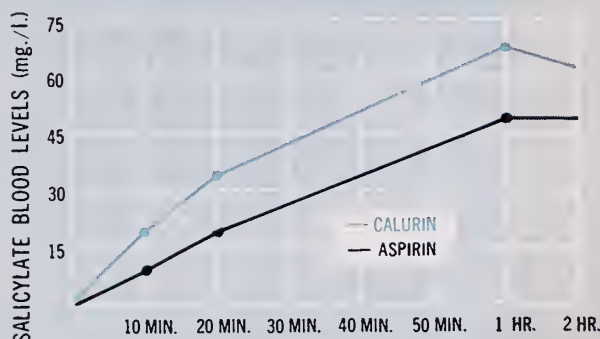


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**REFERENCES** 1. Waterson, A. P.: Aspirin and gastric haemorrhage, *Brit. M. J.* 2:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic observation of the effect of aspirin and certain other substances on the stomach, *Lancet* 2:1222, 1938. 3. Editorial Comments: The effect of acetylsalicylic acid (aspirin) on the gastric mucosa, *Canad. M. A. J.* 80:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, *Brit. M. J.* 2:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, *Lancet* 1:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, *Gastroenterology* 32:1, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, *Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco*, June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, *New Eng. J. M.* 258:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, *New Eng. J. M.* 258:219, 1958. 10. Editorial: Aspirin plain and buffered, *Brit. M. J.* 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium salicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

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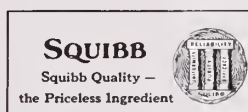
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
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## ALBERT H. MILLER — *Physician*

MEYER SAKLAD, M.D.

The Author: Meyer Saklad, M.D., of Providence, Rhode Island. Chief, Department of Anesthesiology, Rhode Island Hospital.

*"Few surgical fatalities are due to faults in surgical technic. They result rather from depressed or otherwise abnormal condition of the patients, from lack of preparation, from attending features of the operation, such as abnormal postures and improper operating room conditions, and from faulty administration of anesthetics. It is the duty of the anesthetist to understand and to safeguard the patient's physical powers."*<sup>36</sup>

THESE BELIEFS of Albert Miller were written twenty-three years after he had established the Department of Anesthesia at the Rhode Island Hospital. They were written, not so much to point out deficiencies as to plot out for himself, as well as for others, the direction in which studies and labors should extend to improve the lot of the surgical patient. His professional life was committed to the thesis that "It is the duty of the anesthetist to understand and to safeguard the patient's physical powers." To "understand" he studied patients preoperatively, during the operative phase, and postoperatively. To "safeguard" he investigated the hazards of clinical endeavor, surgery and anesthesia. When he determined some of the dangers inherent in these practices he tried to find some way to eliminate or minimize them. In great measure he succeeded, for much of the growth and direction of the practice of surgery in this community is a result of Albert Miller's concern with the welfare of the patient and his endeavors to improve the patient's ability to tolerate some of the ill effects of surgical intervention. His contributions\* were many and his influence was felt throughout the entire world. Modern-day anesthesia is indebted to him for his pertinent and accurate observations.

*"... Surgical fatalities ... result ... from depressed or otherwise abnormal condition of the patients, from lack of preparation...."*

\*See appended bibliography.

From the very beginnings of surgery some patients did poorly or succumbed from the effects of anesthesia and operative procedures. It had been generally accepted that those in poor condition did not do as well as those who were in good physical status. Doctor Miller was among the early few who set out to determine specifically what, in the patient's preoperative condition, might alter his chances of ultimate recovery. To do this required evaluation of the patient. This was accomplished with difficulty for there was resistance to such a procedure. He notes "The advantage of a preliminary physical examination would seem to be self evident but its adoption met with considerable opposition. . . . Some surgeons seemed to consider it a personal affront that their patients should require a physical examination before a contemplated operation."<sup>74</sup> Doctor Miller himself carried out the preoperative physical examination, and by his example, interest, and gentle tact he finally succeeded in establishing this practice as a real need.

His preoperative studies of patients were painstaking. He noted the patient's age and appearance, condition of heart and lungs, urinalysis, and blood pressure determination. Detailed records of these examinations were kept, and as a result he was able to correlate preoperative findings with postoperative complications. His scientific acumen may be recognized by the way he avoided the pitfalls of many such statistical studies, for he wrote "As the examination is made from the anesthetic standpoint, the surgical condition is noted in a general way but is not particularly studied."<sup>27</sup>

He studied the relationship of age and postoperative complications and determined that, in cases where complicating organic disease was discovered at the preliminary examination, the mortality rate in patients over 50 was 14 times as great as that in patients less than 50 years of age. He studied the influence of demonstrable cardiac lesions on surgical prognosis and noted they have little effect in the production of postoperative mortality.

*continued on next page*

On the basis of such studies he established a classification of patients as to operative risk. In Class A were patients free from organic disease whose surgical condition was not likely to prove fatal. Class B patients were those suffering from organic disease, but whose surgical condition was not especially serious, and in Class C were those whose surgical condition was so serious or so far advanced that fatality was likely to result. He commented that all the patients in the first class were expected to recover. All operations on patients in the second class were approached with less assurance, and major operations were performed only when urgently required. In the third group when operations were urgently necessary, a high degree of mortality was to be expected.

Studies of several thousand consecutive patients revealed that it was possible to recognize preoperatively some unnecessary hazards. With such supported conclusions at hand he spread far and wide a plea for delay in operating on patients with conditions which might be improved to lessen the dangers of surgery. Preoperative study of patients is now generally practiced, for it is recognized that such evaluation reveals deficits, and deficits once recognized are apt to be corrected. The lesson Doctor Miller taught the surgical world was an important one—one unfortunately that has to be relearned from time to time.

*"... Surgical fatalities are due to ... attending features of the operation, such as abnormal postures and improper operating room conditions. . . ."*

Doctor Miller studied the changes in physical signs of patients undergoing surgery. These observations, coupled with a personal knowledge of the patient's preoperative physical state, enabled him to determine the differences in the tolerance of individuals to surgical intervention. He recognized the role of blood pressure determination in evaluating changing circulatory states, and as a result much of the early information in regard to shock in the operating room stemmed from his studies. It was in the detection of shock that he believed blood pressure determination had its most practical value. He played an important role in the establishment of determining blood pressures routinely, and his studies revealed the direct relationship between hypotension and blood loss, trauma, and changes in posture.

Continued close observation of blood pressure changes during surgery led him to be perhaps the first doctor to recognize the effect on blood pressure produced by traction on the uterus or gallbladder, manipulation of the intestine, and the intra-abdominal introduction of gauze packing. He noted that removal of a large abdominal tumor was often associated with precipitous hypotension.

He recognized the dangers of some surgical pos-

tures and wrote: "Besides such well recognized causes of preventable surgical deaths as broken asepsis, insecure ligatures and incompetent anesthesia, the influence of ill advised posture must also be considered."<sup>64</sup> Doctor Miller for years had been concerned with the effect of anesthesia on respiration and many of his most important studies were in this connection. He determined that placing the patient in some surgical postures interfered with the patient's ability to ventilate himself properly. He found that when patients were placed prone, they developed a marked respiratory handicap, and he went to great effort to discover the various means which might be used to employ this position with minimum hazard to the patient. He measured the degrees of respiratory involvement occasioned by placing patients in various surgical postures. He was always an advocate of conservative and slow changing of patients' positions. He devised a series of symbols to denote the various surgical postures and recorded them religiously on his chart so that he could correlate alteration in the patient's condition with changes in surgical posture.

*"... Surgical fatalities are due to ... faulty administration of anesthetics."*

In 1899, as a surgical resident at the Rhode Island Hospital, he wrote the first of his many contributions to the field of anesthesia. In this article he emphasized the dangers to the patient of oxygen deprivation, and showed how oxygen want was an ever-present accompaniment of nitrous oxide anesthesia as then practiced. He submitted an improved and safer technic for the administration of nitrous oxide employing an open cone, as a preliminary to ether anesthesia. This method, he believed, was first used at the Rhode Island Hospital, and he claimed that it increased the safety of the patient, inasmuch as "Cyanosis and danger of asphyxiation are done away with, and the patient constantly breathes fresh air."<sup>1</sup> This was indeed revolutionary, as heretofore nitrous oxide had been administered to patients with no oxygen added, with inhalers into which there was no possibility of the ingress of air. His understanding of the need to meet oxygen requirements led him to early adoption of the practice of adding oxygen to nitrous oxide. He later described an apparatus which he had devised for the production of nitrous oxide-oxygen anesthesia, wherein physiologic requirements were more nearly satisfied.

He recognized that not only may improperly given anesthesia cause death, but that, even when ideally administered, it may expose the patient to dangers. He noted that the ill effects of anesthesia may be delayed, and he studied the postoperative mortality from anesthesia. In a series of 5,000 patients he determined the relative effects of nitrous oxide anesthesia and ether anesthesia to postopera-



tive circulatory complications, with specific regard to phlebitis. He extended his studies to the occurrence of coronary embolism, cerebral embolism, cerebral hemorrhage, and pulmonary embolism in relation to the anesthetic agents employed.

In his usually modest and restrained fashion Doctor Miller stated, "Our methods of administering anesthetics do not bear investigation well. Unmeasured amounts of these powerful agents are employed to produce what some authorities are fond of calling 'absolute surgical anesthesia.'"<sup>28</sup> He felt that deep ether anesthesia contributed to shock and endeavored to keep the dosage of anesthetic agents small. His early appreciation of the fact that the signs of anesthesia were indistinct and that anesthetics were administered by guess rather than by rule led him to make one of the most important observations in surgery and anesthesia. It was Doctor Miller's brilliant power of observation which with his accurate recordings led to his discovery that, with increasing depth of anesthesia, the intercostal muscles of respiration become paralyzed before the loss of diaphragmatic respiration. His article titled *Ascending Respiratory Paralysis Under General Anesthesia*<sup>40</sup> was his greatest single contribution and placed the administration of anesthesia on a scientific basis. This article is today universally accepted as a cornerstone of anesthesia progress, for it was the first time on this continent that a physician had carefully labored to observe, identify, record, and correlate the sequence of abolition of respiratory reflexes and responses to the increasing depth of ether anesthesia. Although this had been done previously by John Snow in England, this work was poorly known throughout the world. It was because of Doctor Miller's observations that Doctor Guedel later used Doctor Miller's findings as a basis for the Guedel classification of planes and stages of anesthesia.

Recognition of the sequence of paralysis of respiratory musculature was based upon observation and was later supported by pneumographic studies by Doctor Miller. This continued interest in the importance of thoracic and diaphragmatic respiration under anesthesia led him to recognize the extent of the hazard of poor posture on the table and to decry the interference with bodily function by placement of an anesthetized patient in the prone position. Doctor Miller's knowledge in this field led him to point out that, contrary to what was the almost universal practice, it is important on occasion to lighten ether anesthesia to improve surgical exposure. He knew that exaggerated movement of the abdomen was due to excess diaphragmatic activity because of intercostal paralysis. It had been mistakenly accepted that excess motion during surgery within the upper abdomen was probably due to light anesthesia and attempts to quiet over-

active abdominal motion by deepening anesthesia resulted in overdosage and often in death.

Among his contributions to new technics was one which not only contributed to improved comfort and safety of the patient, but also had a direct influence on the advancement of surgery. This was his technic of pharyngeal anesthesia. Doctor Miller records that this was first carried out at the Rhode Island Hospital. This procedure allowed for the continuous administration of a potent anesthetic agent while allowing the surgeons to work unhampered in the upper respiratory passages; the mouth, nose and throat. It also made possible the administration of smoother and better anesthesia for cranial surgery and for surgery in unusual postures. The technic of pharyngeal anesthesia as first devised was by the use of a foot pump. This, however, was soon supplanted by a motor compressor. An important result of this effort was that Doctor Miller evolved a method for the administration of ether wherein ether concentration was always exact, a tremendous forward step in making anesthesia safer. His belief in exactness was characteristic of all his endeavors. He repeatedly spoke of the necessity of always measuring the amount of ether administered, whether by drop or by vaporizer.

Throughout his work he evidenced concern with the comfort and convenience of the patient, for when he developed a new inhaler for nitrous oxide-oxygen anesthesia, it was so devised that a specially provided valve would allow the patient to breathe room air for a period before induction. The introduction of this particular valve is interesting, for it incorporated a far-advanced design. What he had developed at that time is now being used throughout anesthesia as a non-rebreathing valve. I believe there were occasions when he did use the valve in this fashion, but nowhere in his writings is he explicit in this regard.

Another contribution of Doctor Miller's to the welfare of the patient and to improved surgical practice was his work in connection with intrathoracic surgery. He developed a method of administration of anesthesia to patients undergoing surgery within the chest cavity, which protected the patient from the hazards of surgical pneumothorax. The technic for positive pressure anesthesia was devised specifically for the transthoracic repair of diaphragmatic hernia. Doctor Truesdale's success in the development of the operation for this condition was dependent entirely upon Doctor Miller's ability to keep the patient anesthetized and alive.

In an article he wrote concerning anesthesia for chest surgery he demonstrates his great understanding of the physiologic principles concerned. He recognized the adverse effects of elevated intrapulmonary pressure on mediastinal structures and

*continued on next page*



upon the efficiency and function of circulation and respiration. It was only after he had thoroughly acquainted himself with efforts previously made to establish safe differential pressures for intrathoracic surgery that he developed an apparatus for the administration of anesthesia for this type of surgery.

Doctor Miller's name should be added to that small group of pioneers who demonstrated that surgery within the thorax is compatible with life and who pointed the direction to take whereby mortality due to surgical pneumothorax was reduced to its present-day low level. Although the method devised by Doctor Miller is no longer used today, it was the basis for the development by Doctor Barach years later of a method of maintaining constant positive pressure breathing.

*"It is the duty of the anesthetist to understand and to safeguard the patient's physical powers."*

Doctor Miller took seriously his responsibility for the patient. He believed himself "a silent watcher of the thread of life, ready to maintain the integrity of that thread by every means obtainable from study and application."<sup>30</sup> He would allow no improper placement of patients on the operating table. His patients were always protected from oxygen want by satisfactory airways and the addition of oxygen to the ether cone. Never were his patients overdosed and he would withstand with calmness and great dignity the pleas of surgeons for deeper anesthesia. He knew the hazard of surgery and anesthesia on patients in poor condition, and, as previously stated, he would plead for delay in surgery to allow for improvement in their physical status.

Knowing of the hazards of anesthesia and the dangers of surgery, he maintained a constant vigil over his patients, recording at regular intervals the effects of external influences on bodily function by changes in vital signs. He was among the very earliest to develop and use an anesthesia record. Although anesthesia records were developed earlier by Doctors Codman and Cushing in Boston, it is believed that the first continuous use of anesthesia records was begun at the Rhode Island Hospital. These records were the basis for constant review of patients and served as a continuing source for study of the myriad effects of anesthesia and surgery.

He was a student of the history of anesthesia, especially as it concerned Wells and Morton. This interest extended to consideration of the actual creation of the word "anesthesia." He reported on a visit to the birthplace of Morton and on the occasion of a gathering of anesthetists at the grave of Morton he rendered an address. He was interested in the historical aspects of inhalation therapy in general, but he was especially interested in the work

of Thomas Beddoes, a pioneer in this form of therapy. He contributed to the literature on the technic of inhalation therapy and resuscitation.

Throughout all his writings there is evidence of his interest in statistics. His studies of the classification of patients, and his use of anesthesia records to show the circulatory effects of anesthesia and surgery extended into proposing a numerical system of hospital records.

In 1931, the Rhode Island Medical Society honored him with the Fiske Fund Prize for his essay titled *Anesthetics — Their Relative Values and Dangers*.<sup>53</sup> This contribution is an excellent summary of the pharmacologic effects of various anesthetic agents and narcotics. Herein he reviewed briefly some of the methods of inhalation anesthesia. He devoted a considerable portion of the effort to a statistical study concerned with the safety of anesthetic agents. On the last page of the essay he rated anesthetics in the order of their comparative value under different conditions. This article is noteworthy for its bibliography.

Doctor Miller spent much time in teaching. In this he had much of the zeal of a missionary. He believed firmly that no surgeon could be a good surgeon unless he had training in anesthesia. He held weekly meetings with interns in the basement of the old Rhode Island Hospital building. Here he lectured and held discussions on anesthesia. It did not require the usual distribution of cigars to entice the interns to return for the following week's talk. He instilled into the minds of a generation of surgeons the need for consideration of the dangers of interference with physiologic processes during surgery.

In 1935, Doctor Leo V. Hand was appointed full-time resident in anesthesia. This had great significance, for there had been a time when the progress of anesthesia had been threatened by the increasing use of technicians for administration. This trend was resisted in Rhode Island, primarily because of Doctor Miller's belief that anesthesia could develop and progress only if its future were entrusted to physicians who had good knowledge of physiology and pharmacology. The fact that a young man of Doctor Hand's ability could become interested in the specialty as his life's work attested to Doctor Miller's success.

He exhibited some prophetic vision, for at one time he stated, "Perhaps the tongue forceps and mouth gag will next give place to the electrocardiograph. At all events, the future anesthetist will take every advantage of the hour of precaution, which is worth more than a thousand years of regrets."<sup>18</sup> It took a hiatus of many years, but today the electrocardiograph and other such monitors are enabling the anesthetist to take advantage of "the hour of precaution."

ALBERT H. MILLER: *The Art of Anesthesia*

LEO VINCENT HAND, M.D.

---

The Author, *Leo Vincent Hand, M.D., of Boston, Massachusetts. President-Elect, American Society of Anesthesiologists, Inc.*

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IN THE RECENT LITERATURE we have increasing evidence of the rapid strides and increasing knowledge pertaining to the science of anesthesiology. This is proper and progress. But as is true of all progress, it is built upon the steppingstones of the past. It is of this past, more properly known as the *Era of the Art of Anesthesia* I now write, and in particular of the contributions of a great pioneer, our beloved Albert Miller, an outstanding teacher with a keen intellect and one always interested in clinical research.

He truly is accorded the title of "Master." He, with the other great pioneers, Gwathmey, Flagg, Richardson, Allen, Sise, Waters and Lundy to name but a few, truly was instrumental in today's progress.

What is the *Art of Anesthesia*? Possibly the most concise and inclusive definition is best expressed in the words of Flagg. "It will be perceived that while a knowledge of laws is essential, yet this knowledge is superseded by the ability to properly apply them. This controlling element is what constitutes the essence of the Art. Experience begets dexterity, tact and skill. These qualities, while somewhat intangible, are nevertheless indispensable. They imply a correct and spontaneous response to the demands of the patient. The *Art of Anesthesia* implies an intimate knowledge of general medicine, pathology, surgery, therapeutics, psychology and special branches. Those who are not familiar with these subjects cannot understand the language (the Art) of anesthesia."

The above concisely portrays Doctor Albert Miller: "ability to properly apply," "experience, dexterity, tact, skill" and an "intimate knowledge" of the above branches of medicine. It is these, his intangible but nevertheless indispensable qualities that I, his first resident in the newly formalized specialty of anesthesia at the Rhode Island Hospital in 1935-36, clearly recall. Many of our colleagues in the Rhode Island Hospital were indeed fortunate to have a brief period under his instruction while they served a two-month period in anesthesia during their internship. It was my good fortune to

spend one additional year as the first resident under Doctor Miller and later under his successor, Doctor Frank Mathews.

*First Impressions*

Some specific experiences are still vivid. His dicta are still valid and applicable to modern, scientific anesthesia. Before I recount these teachings and lessons a work picture of this man in the eyes of his department and in particular his first resident is in order. What were the first impressions upon meeting him, as an intern? As we stand around the operating room supervisor's desk checking the daily surgical and anesthesia schedule we saw coming down the hall toward Nellie Hughes's desk, the Yul Brynner of the Rhode Island Hospital; a man of medium height, slim and trim, with a spring to his step. As he approached the desk and schedule, we heard Nellie Hughes in an audible voice remark: "Here comes bad news, what gadgets today?" They were the best of friends, Nellie was in her usual form with the repartee. We note he was soft-spoken. There was a slight hesitancy to his speech, almost as if he was weighing his words. He had particularly expressive eyes, sharp, bright, but pleasant with a suggestion of a twinkle to them. He observed everything. He was beloved by his department members, nurses and doctors. Many there were but one in particular, Kitty McCloud, stood out. She above all exemplified his teachings: wonderful patient care, kind, sympathetic, always willing and working, pleasant, soft-spoken, gentle and efficient. Her greatest pleasure was to pass along all the "pearls" she had received from the "chief," Doctor Miller. It was always, "Doctor Miller this, Doctor Miller that."

The first lesson in the *Art* from Doctor Miller concerned preoperative visits and preanesthetic medication orders. The usual routine of his era was for the surgeon to evaluate the patient's anesthetic risk and then the surgeon wrote the preanesthetic medication orders. Doctor Miller insisted that the proper practice was for the anesthetist to establish rapport with the patient, study in detail the medical records, check if necessary his own physical findings, evaluate the patient's physical status or risk together with his emotional condition and then order adequate and proper preanesthetic medication. Such practices controlled metabolic activity

*continued on next page*



thus insuring a well-sedated, non-apprehensive and co-operative patient for induction of anesthesia. This exemplified the qualities of tact, and understanding of patient psychology and intimate knowledge of therapeutics.

It was from Doctor Miller I received my first lessons as to how to prepare the patient in order to insure ideal conditions for anesthesia induction and maintenance. With sympathetic understanding he obtained the patient's confidence. With the skillful use of drugs, morphine and atropine, he depressed metabolic activity, emotional excitement and tensions. With these drugs he lessened vagal reflex activity and obtained conditions which enhanced the passage of the agent, usually ether, from the lungs into the blood stream.

He lectured long and frequently on the safety of a properly administered ether anesthesia. He was and still is an authority on the use of ether and its advantages. To again quote Flagg in his book: "as stated by Miller, — it is properly administered. It is also undoubtedly true, that any other anesthetic handled with the gross negligence with which ether has been administered would long ago have been discarded."

### *As a Teacher*

The following are but a few of his teachings as to "the ability to properly apply." Always use adequate oxygen when employing any agent. When using nitrous oxide always maintain an 80-85% nitrous oxide 20-15% oxygen mixture. On the old Gwathmey machine "four holes of nitrous, one hole of oxygen bubbling at all times." While he demonstrated the "secondary saturation" nitrous oxide technic he did not approve or advocate its use. He always insisted, and it since has been substantiated, that such a technic was a hazardous and dangerous procedure. Such initial anesthesia was obtained by severe hypoxia. He carried his teaching one step further and demonstrated that with confidence and time, not only was a hypoxic induction unnecessary (a prevailing practice of this era) but also more ideal operating conditions were obtainable with his careful ether cone technic. By gravity nitrous oxide-oxygen was administered through this properly constructed cone to which ether, slowly and carefully was added. It resulted in a very smooth transition from analgesia to surgical anesthesia. He indeed was twenty years ahead of his era.

It was in the administration of ether that he was the artist. He often stated the best ether anesthesia required not only skill but constant attention to detail. The first important detail was the equipment, the *cone*. He modified the old routine paper, towel covered, ether cones. He insisted that an optimal rebreathing area was a necessity in all cones. With

his specially built ether cones with metal diaphragms, covered with 6-8 layers of gauze, one could carefully and confidently anesthetize any patient for most surgical operations with as little as 4-8 ounces of ether for a 2-4 hour operation. This ether was dropped, not poured, on the gauze slowly so that the patient's heated exhalations volatilized the liquid to a gaseous state. He always insisted that the best and proper anesthesia demanded more than an ether cone slapped to the patient's face and then this cone saturated, frequently dripping with ether. As he often stated, "anesthetize the patient with the fumes, do not burn or drown him with the liquid." Ether anesthesia was thus obtained by volatilizing the fluid and the patient then inhaling the fumes to which was frequently added a constant flow of oxygen by means of an oxygen catheter. Such a technic resulted in a smooth transition into and maintenance of the third plane of the surgical stage of anesthesia. Again evidence of his skill, dexterity and ability to properly apply.

Another "pearl": "a wet patient is usually an anoxic (hypoxic) patient. An anoxic patient is rarely adequately relaxed irrespective of the depth of anesthesia." Oh how true!! This "pearl" recalls to mind a vivid recollection of his qualities of understanding, tact and judgment. One morning during a hectic schedule I was called into the gynecology operating room because of difficulties of relaxation during a trying period of pelvic surgery. The nurse anesthetist was almost in tears, the surgeon, Dr. G., was very disturbed and was insisting that the anesthetist increase the depth of anesthesia in order to obtain the necessary relaxation. The nurse stated the patient was "deep." The surgeon insisted the patient was "light." I, with an exaggerated idea of my supervising importance, decided to "give the surgeon a lesson." I took over. I increased the depth of anesthesia into the fourth stage or stage of respiratory cessation, just short of cardiac arrest. I then informed the surgeon that the patient was now "almost dead" and that the operating conditions were unchanged. The surgeon almost had apoplexy. I still remember Doctor Miller's words on this occasion: "There are many other ways of killing the cat than choking him to death with butter." "Leo, you first jeopardized the patient; second, you further disturbed the surgeon when he had problems, and was already greatly disturbed. You could have accomplished all you desired by using judgment and simply adding oxygen to your anesthesia. You could have discussed the conditions and facts later under better conditions. There were many ways physiologically and psychologically you could have accomplished your primary purpose, patient safety and optimal operating conditions."



*A Keen Clinical Investigator*

I mention "depth of anesthesia." To Doctor Miller we are indebted for his classical review of the respiratory signs of Anesthesia. He has received surprisingly little credit for his original and classical work. Others that followed have added some modifications and these modifications are now popularized in the literature. His basic review has been unchanged. All this demonstrates and is evidence of his keen clinical investigative and correlative skill, indeed he was ahead of his era and without a peer. His original work has been our standard for the past forty years.

His teachings were not in inhalation anesthesia alone. A few spinal anesthetics were of the procaine barbitage technics and used primarily in genito-urinary surgery. Intravenous anesthesia was limited to the barbiturate Evipon. This agent and method was not approved by Doctor Miller. Rectal anesthesia also was poorly controllable and large doses were recommended based on German technics. Because of the poor control and large doses recommended very little intravenous or rectal anesthesia were employed. As ether then was the most controllable agent and had and still has the widest margin of safety it was his agent of choice. Heavy medication was employed to lower metabolic activity. Despite widespread usage, chloroform was not approved or employed, because of its hepatotoxic and cardiotoxic dangers. Present-day practices confirm his opinion as to its hazard. Again Doctor Miller with his keen judgment and astute knowledge was a leader in this specialty.

His teaching was not limited to the Rhode Island Hospital. He was a prolific writer not only concerning anesthesia but he was also a historian of distinction. Combined with his writing and teaching he was an avid collector of books, journals, reprints and pamphlets on anesthesia and allied subjects. He had, and I presume still has, an extensive library. I do know he had the only complete library of the editions of the first and foremost publications in anesthesia, ANESTHESIA AND ANALGESIA. The early volumes of this Journal are collectors' items.

Indeed I realize in closing that this is but a sketchy word picture of a great pioneer and an excellent teacher. Indeed he was a leader, a man ahead of his era in both clinical practice and investigative research in anesthesia. He inspired confidence in his patients and affection and respect from his subordinates. He was beloved and respected by all who came in contact with him; patients, surgeons, associates, subordinates and students. Indeed he had all the attributes and qualities that Flagg states so necessary to understand and practice the *Art of Anesthesia*: experience, dexterity, tact and skill; all combined resulting in a correct

and spontaneous response to the demands of the patients, his first and foremost consideration.

**ALBERT H. MILLER — PHYSICIAN**

*continued from page 582*

Doctor Miller, in opening a paper describing the growth of anesthesia in Rhode Island, quoted Abbé Henri Breuil who had said "Every being, every thing, every institution, derives, at least in greater part, from its antecedents, and is, in turn, at least in greater part, the starting point of the realities which follow it."<sup>74</sup> It is proper that we acknowledge our indebtedness to our antecedents by stating that "at least in greater part, the starting point of the realities" of the present status of anesthesia is derived from Albert Miller.

In 1902 he wrote, "To relieve pain and prolong life, these are the aims of medicine, and anesthesia, during its short fifty years of existence has not been the least of the means for producing these results."<sup>3</sup> These words were written fifty-seven years ago, and this ideal became his personal aim, in which he succeeded well. But transcending his personal success is his achievement in transmitting to us his teachings by example and recorded word.

We are grateful that, because of him, we who are privileged to try "To relieve pain and prolong life," can do so with greater safety and success.

**BIBLIOGRAPHY — DR. ALBERT H. MILLER**

- <sup>1</sup>Nitrous Oxide and Ether Anaesthesia by the Open Method. *Ann. Surg.* 30:12:709-714, December, 1899
- <sup>2</sup>Nitrous Oxide Anesthesia in General Surgery. *Providence Medical Journal* 2:2:83-86, April, 1901
- <sup>3</sup>Post-operative Mortality with Especial Reference to Death from Anesthetics. *Providence Medical Journal* 3:11:201-205, November, 1902
- <sup>4</sup>Surgical Anesthesia. *Am. J. Nursing* 5:1:25-28, October, 1904 and 5:2:97-100, November, 1904
- <sup>5</sup>The Seashore Treatment of the Tuberculous Arthritis of Children. *Boston Med. & Surg. J.* 157:659-661, November 14, 1907
- <sup>6</sup>The Value of Ethyl Chloride as a General Anesthetic. *Boston Med. & Surg. J.* 160:20:643-645, May 20, 1909
- <sup>7</sup>A New Device and Method for Administering Ether. *Surg., Gyn. & Obst.* 8:639-640, June, 1909
- <sup>8</sup>Anesthesia for Adenoid and Tonsil Operations. *Boston Med. & Surg. J.* 161:3:87-88, July 15, 1909
- <sup>9</sup>A New and Satisfactory Apparatus for Etherization in Operations About the Face and Upper Air Passages. *J.A.M.A.* 53:17:1353-1355, October 23, 1909
- <sup>10</sup>The Choice of the Routine Method for Administering Ether. *Providence Medical Journal* 11:11:290-296, November, 1910
- <sup>11</sup>Surgical Anesthesia. *Trained Nurse and Hospital Review*, June, 1912
- <sup>12</sup>Postoperative Mortality from Anesthetics: The Recorded Death Rate From Ethyl Chlorid. *J.A.M.A.* 59:21:1847-1848, November 23, 1912
- <sup>13</sup>The Dosage of Cocain and Other Drugs Used for Producing Local Surgical Anesthesia. *J.A.M.A.* 62:196-197, January 17, 1914

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*Bachrach photo*

ALBERT HENRY MILLER, M.D.

## THE LIFE OF ALBERT H. MILLER

A Factual Account of Doctor Miller's Life Based on Data Furnished by his Wife,  
Mrs. Ada Holding Miller, to Doctor Alex M. Burgess, Sr.

TO THOSE of his colleagues to whom his life and work and his endearing personality have been an inspiration, a simple account of the sequence of events in his training and professional career will be of interest. Elsewhere in this issue there appear articles by two distinguished anesthesiologists who knew him as a great leader in the field in which they were in training, and who followed in his footsteps.

Doctor Miller was born in Lewiston, Maine, on April 3, 1872. He was graduated from Bates College in 1894, and a year later from the School of Science at Bowdoin. In 1898 he received the degree of Doctor of Medicine from the College of Physicians and Surgeons, Columbia University, New York. The next year he spent as intern at the Central Maine General Hospital at Lewiston and served a second year of internship at the Rhode Island Hospital.

He was appointed anesthetist to the Rhode Island Hospital in 1900, and shortly thereafter to St. Joseph's Hospital and Memorial Hospital, Pawtucket. He later became anesthetist to Providence Lying-In Hospital, Butler Hospital, South County Hospital, Truesdale Hospital, Fall River, and others. His achievements in his field are well described in the articles by Doctor Saklad and Doctor Hand, and a complete bibliography of his publications is appended to the former article.

It is worthy of note that immediately after his appointment at Rhode Island Hospital as anesthetist, his first decision was to do away with the old, closed-cone method of giving ether. The cone used was made from woven Butcher's cuffs which were covered with an oiled silk and completely closed at one end. Doctor Miller substituted an open cone he had invented and his new method came under close scrutiny of a group of surgeons appointed by the trustees of the hospital. Subsequently the surgeons reported that Doctor Miller was not only having spectacular results with particular comfort to the patients, who could now take an anesthetic without a choking feeling, but he was also saving ether instead of wasting it. The method he initiated is still used.

Doctor Miller also developed a method of anesthesia for intrathoracic surgery, which he called "constant pressure nitrous oxide-oxygen anes-

thesia." Before this method was used the mortality from diaphragmatic hernia was more than 50%. Following the introduction of the new method Doctor Miller handled twelve cases of diaphragmatic hernia without a single death.

His work was appreciated both in the United States and abroad. He was president of the American Society of Anesthesia in 1918 and again in 1920, president of the Eastern Society of Anesthesia in 1927 and of the Boston Society of Anesthesia in 1926, 1927, and 1928. In addition, he was chairman of the American Medical Association Section on Anesthesia in 1933. With Doctors E. I. McKesson and Adolph Erdmann he served on the Record Committee of the International Anesthesia Society. From this society he received the medal and cup award with this statement, "From the Associated Anesthetists of the United States and Canada as a token of appreciation for splendid services in this organization; for research, practice, and teaching of anesthesia."

It is interesting to realize that while a student he worked under such great surgeons as Bull and McBurney, and it was the influence of the latter that was largely responsible for his decision to specialize in anesthesiology. Other great clinicians, one of whom was Doctor Francis Delafield, shared in the responsibility of training him in medicine.

He is credited with the introduction, in 1899, of gas oxygen-ether anesthesia which was widely used after initial demonstrations at Massachusetts General, Boston City, and the Harlem (New York) hospitals.

In 1906, with Dr. Halsey DeWolf, of Providence, he established the Garland Ward on Jamestown Island where crippled children received special treatment utilizing sea water and bathing exercises, and special diets, a revolutionary program at the time, but later generally used in rehabilitative work.

Besides his work in his own specialty, Doctor Miller had broad, general interests in his profession. He was president of the Providence Medical Association in 1925-1926 and of the Rhode Island Medical Society in 1934-1935. From 1924 to 1927 he was editor of this Journal and he was managing editor from 1937-1942.

He was interested in medical history, especially



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# The RHODE ISLAND MEDICAL JOURNAL

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## HONOR TO A PROPHET IN HIS OWN COUNTRY

IN THIS ISSUE the Journal honors itself by doing honor to one of the most distinguished physicians in the history of Rhode Island, to whom it owes a great deal, Doctor Albert H. Miller.

Doctor Miller, a world leader in the field of anesthesiology, was, as noted in the account of his life that appears on another page, at one time editor-in-chief and managing editor of this Journal. His work in these positions was carried out with characteristic diligence, tact and skill, and was essential in bringing about the excellence this publication achieved in its earlier years. It is the hope of the present editors and the Publication Committee, a hope that beyond a doubt is shared by the entire membership of the Rhode Island Medical Society, that now, as he is retired and can contemplate in retrospect the fruitful years of his professional career, he may derive some degree of satisfaction from the affectionate tributes of his colleagues that appear in this issue.

The two major articles, by Doctor Meyer Saklad and Doctor Leo Hand, bear eloquent testimony to his great achievements as a leader in the practice and teaching of his specialty and as an investigator who made great advances in his field. He is truly a scholar and a gentleman. Doctor Saklad, now himself internationally renowned as a leader in his field, has made a careful and detailed study of Doctor Miller's career with which he was person-

ally very familiar. There is no one better able to give a real estimate of the life work of Doctor Miller, and this Doctor Saklad has done.

Doctor Hand, the first physician to work as resident under Doctor Miller, and now a distinguished anesthesiologist in a neighboring city, in his article has added a personal touch by which he makes the picture of his former chief still more human and inspiring.

There are, we are sure, hundreds of others of the profession who, if they had the opportunity to do so, could contribute many pages filled with incidents and experiences which would bear testimony to the professional skill and the human understanding and kindness that have always characterized this man. It is indeed a privilege to dedicate this issue of the Journal to our distinguished colleague.

## "CENTRALIZING HEALTH DRIVES MAKES SENSE"

An editorial appearing in a prior issue of this Journal discussed the problem of the multiplicity of fund-raising drives by voluntary health agencies. It was then suggested that "there might . . . be some gain in combining or co-ordinating among themselves their fund-raising and fund-dispersing activities."

It is of interest to note that the American Heart Association has recently decided to convene a com-

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**"CENTRALIZING HEALTH DRIVES MAKES SENSE"**

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mittee of physicians, scientists and community leaders to study the increasing number of fund-raising drives by such agencies. The announcement spoke of the "public confusion" caused by "the increasing number of appeals for support." This announcement was soon followed by endorsement of the plan by the American Cancer Society.

We agree most heartily with the quotation at the head of this column. It was the caption of an editorial in the ST. LOUIS POST-DISPATCH (quoted in THE EVENING BULLETIN of Providence) which further stated: "Most of us would be grateful for an objective survey of the urgency of research projects, and for a new approach to their support, an approach which would make it more nearly certain that contributions were used to do the greatest good for the greatest number."

The American Heart Association is to be congratulated for taking a new and critical look at the touchy and emotional problem of multiple fund-raising drives.

**THE LIFE OF ALBERT H. MILLER**

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in the development of inhalation therapy and anesthesia. A real knowledge of history and of the Bible were his cherished possessions, and his principal hobby was his music. His wife, Mrs. Ada Holding Miller, to whom the writer is indebted for the details given in this factual account of his life, and who is a distinguished musician, says that, "For relaxation, after a heavy day, he would take off his coat, roll up his sleeves, and play Chopin hour after hour." He played the piano and the pipe organ very well.

In his life and work Doctor Miller carried out the principles of the Christian religion. He said, "I know that pain and death are necessary for life," but he believed that freedom from pain is one of the greatest blessings that can come to a human being. The alleviation, and even more the prevention of pain, safely and scientifically, and the search for even better methods of securing this result, were the objectives to which the major effort of his life has been dedicated, and in which his success has been outstanding.

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**MEDICAL EDUCATION PROGRAM**

**RHODE ISLAND HOSPITAL**

George Building Auditorium at 7:30 P.M.

Thursday, October 22, 1959

**HANS POPPER, M.D.**

Pathologist-in-Chief, The Mount Sinai Hospital;  
Professor of Pathology, Columbia University

*Transition of Hepatitis into Cirrhosis*

Monday, November 30, 1959

**WILLIAM B. SCHWARTZ, M.D.**

Senior Physician, New England Center Hospital;  
Professor of Medicine, Tufts University School  
of Medicine

*The Diagnosis and Management of  
Urinary Tract Infections*

Friday, December 18, 1959

**JAMES C. WHITE, M.D.**

Chief of the Neurosurgical Service, Massachusetts  
General Hospital; Professor of Surgery,  
Harvard Medical School

*Neurosurgical Procedures for the Relief of Pain  
in Malignant Disease*

Friday, January 15, 1960

**HENRY L. JAFFE, M.D.**

Director of Laboratories, Hospital for Joint Diseases,  
New York City

*Bone Tumors: The Correlation of the Clinical and  
Roentgenographic Findings with the  
Pathologic Findings*

Friday, April 22, 1960

**JOSEPH F. URICCHIO, M.D.**

Assistant Professor of Medicine, Hahnemann  
Medical College;  
Cardiologist, Bailey Thoracic Clinic;  
Staff Physician, Hahnemann Hospital;  
Staff Physician, Children's Heart Hospital;  
Consultant, Veterans Administration Hospital

*A Medical Appraisal of Open Heart Surgery*

## KAPOSI'S SARCOMA (Angioreticulomatosis)\*

BENCEL L. SCHIFF, M.D.

The Author, *Bencil L. Schiff, M.D., of Pawtucket, Rhode Island, Assistant Clinical Professor of Dermatology, Boston University School of Medicine; Dermatologist, Pawtucket Memorial, Miriam, Rhode Island, Charles V. Chapin, and Notre Dame hospitals, and at State Hospital for Mental Diseases.*

**K**APOSI'S SARCOMA is usually found in mature individuals. The observation of this disease in the young is rare enough to warrant a report.

### *Report of a Case*

A twenty-four-year-old white American of Portuguese ancestry was seen on October 28, 1958, complaining of an eruption accompanied by swelling, pain and occasional bleeding of the lower left leg and ankle. He stated that the eruption first appeared at the age of fifteen on his lower left leg and eventually spread to his foot, causing him no discomfort. Examination of the dorsum of the left foot revealed bluish red nodules measuring from 2 to 5 mm. in diameter. The lower leg showed a coalescence of nodules forming infiltrated plaque-like lesions. (Fig. 1.) History revealed he had received no systemic or topical treatment.

Laboratory results showed a normal blood chemistry and urine. Roentgenograms of chest and bones revealed no abnormalities.

A biopsy specimen of a nodular lesion from the ankle was reported by Doctor Micolonghi as follows:

Clusters of closely placed capillaries were seen beneath a thinned epidermis. The deeper dermal layers, displayed large, swollen endothelial cells with occasional mitotic figures. In the intervening stroma proliferating, spindle-shaped cells, lymphocytes, plasma cells, extravasated erythrocytes and deposits of pigment were noted. Pearl's stain was positive for hemosiderin. (Fig. 2.) Diagnosis: Kaposi's sarcoma.

Beginning on November 10, 1958, roentgen therapy was administered to the nodular lesion of the dorsum of the left foot. A total of 300 roentgens was given in weekly treatments. This was followed by 70 per cent regression of the lesions. (Factors:

90 Kv. 5 ma. 1 mm. Al. filter, half-valve layer, 1.8 mm. Al. target skin distance 15 cm.)

### *Comments*

This disease was first described by Kaposi in 1872.<sup>1</sup> Since then there has been much controversy concerning its true nature. Every conceivable facet of the disease has been recorded and discussed. As a result, about thirty-three descriptive terms have been suggested. The widespread impression that Kaposi's sarcoma is limited almost exclusively to the Jewish race is not supported by statistics.

DeAmicis<sup>2</sup> reported 50 cases of the disease seen in Italy, and none in this group was Jewish. Doerffel's<sup>3</sup> opinion is that the distribution of Kaposi's sarcoma is geographic rather than racial, since the vast majority of patients appear to be Russian, Polish or Italians.

The disease generally occurs in individuals past middle age, mostly in the 5th, 6th and 7th decades,



FIGURE 1

Kaposi's Sarcoma in a twenty-four-year-old white male

\*From the Department of Dermatology, Boston University School of Medicine (Herbert Mescon, M.D., Professor).



and in men more than in women. The youngest patient was recorded by Chargin,<sup>4</sup> who stated that he had observed a six-month-old infant with Kaposi's disease. Six cases of Kaposi's sarcoma occurring in the second decade were mentioned by Bluefarb.<sup>5</sup>

The etiology is unknown. The disease has been found in nearly every organ of the body, most frequent sites other than the skin being in order of frequency, the gastrointestinal tract, the liver, the lungs and the retroperitoneal and mesenteric lymphnodes.

According to Philippson<sup>6</sup> the oral mucous membrane is the most common localization in the more advanced stages of the disease. So far as is known, the skin is almost always the first organ involved. The skin manifestation consists of various sized macules, papules, tumors, nodules, and plaques. The lesions vary in size from a millimeter to a centimeter in diameter. There may be only two or three lesions or there may be many. Babes<sup>7</sup> counted 450 in one patient.

The lesions may be discrete, coalescent or conglomerate (MacKee and Cipollaro).<sup>8</sup> They are firm, often shiny, rarely translucent and generally well demarcated. They may be round, oval or irregular. Occasionally a combination of infiltrated plaques and discrete nodules produces an extensive hard swelling, so that the involved hands, feet, arms



FIGURE 3

Before and after cathode ray treatment at the Massachusetts Institute of Technology, March-June, 1954, the first case of Kaposi's sarcoma so treated. No recurrences to date (Ronchese and Kern, *Lymphangioma-like tumors in Kaposi's sarcoma*, A.M.A. Arch. of Derm. 75:418-427. March, 1957).

or legs may attain the aspect of elephantiasis.

Unusual cutaneous features resembling lymphangioma circumscriptum or lymphangioma-like tumors have been reported by Ronchese and Kern.<sup>9</sup> It has been thought that the extra-cutaneous lesions were metastatic. However, it is generally believed that such foci are primary and that there is no metastases. Kaposi's sarcoma often runs a slow course with intermittent remissions or exacerbations. Sometimes it may progress rapidly with involvement of internal organs. Death may be due to this or some intercurrent disease. Cases are on record of spontaneous cure, and of regression for years following therapy. The prognosis of Kaposi's in the very young is poor.

Modalities of treatment used in the past consisted of ultraviolet therapy, surgery and chemotherapy and arsenic.

Lately, the cathode ray therapy has shown remarkable results as reported and illustrated by Ronchese and Kern. (Fig. 3.)

## SUMMARY

A case of Kaposi's Sarcoma in a twenty-four-year-old white American male, of Portuguese ancestry, is reported. A brief description of the disease and its treatment is presented. The incidence of this tumor in one so young was felt to be worthy of recording.

## REFERENCES

- <sup>1</sup>Kaposi, M.: Idiopathisches multiples Pigmentsarkom der Haut. Arch. f. Dermat. u. Syph. 4:265, 1872
- <sup>2</sup>DeAmicis, T.: Die sarkomatose der haut. Monatsschr. prakt. Dermat., 25:309 (Oct.) 1897
- <sup>3</sup>Dörffel, J.: Histogenesis of Multiple idiopathic hemorrhagic sarcoma of Kaposi. Arch. Dermat. & Syph., 26:608 (Oct.) 1932
- <sup>4</sup>Chargin, L.: In discussion on Silvers
- <sup>5</sup>Bluefarb, S. M.: Kaposi's Sarcoma, Ed. I. Springfield, Charles C Thomas, 1957

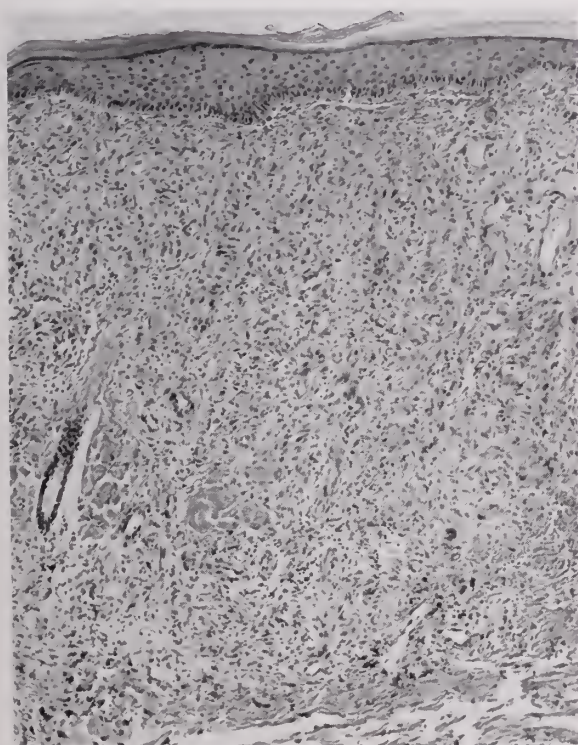


FIGURE 2

Section from a nodule showing vascular dilatation, swollen endothelial cells, spindle-shaped cells.

## ACUTE MASSIVE DIGITALIS INTOXICATION

RICHARD R. KNOWLES, M.D.

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The Author, *Richard R. Knowles, M.D., Assistant Physician, Newport Hospital, Newport, Rhode Island.*

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**A**CUTE MASSIVE DIGITALIS intoxication has been infrequently reported. Bergy et al., recently reviewed the literature and tabulated the outstanding clinical and electrocardiographic changes seen in eight reported cases of acute massive digitalis poisoning.<sup>1</sup> Only two of the reported cases were fatal despite the ingestion in a single dose of various preparations of digitalis in amounts equivalent to 6 mgm. to 50 mgm. of digitoxin. Because of the rarity of reported cases it is felt that the following case is of sufficient interest to warrant a case report illustrating serial electrocardiographic changes.

### Case History

M.K. Newport Hospital #52942. The patient was a thirty-three-year-old housewife who was admitted to the hospital on September 22, 1957, with the chief complaint of "pounding of the heart." Seventeen hours prior to admission the patient ingested 3 oz. of whisky, 5.2 mgm. of digitoxin in the form of 0.2 mgm. tablets, and approximately 24 tablets of dramamine. She was unable to recall what had occurred during the next twelve hours, but according to her children she slept most of the time. However, she awakened at least once during this period and literally tore the front room of the house apart. The first thing the patient could definitely recall was a feeling of intense nausea followed shortly by vomiting approximately twelve hours after ingesting the medication. She vomited six to seven times and had one loose bowel movement prior to admission. She also noted paresthesiae particularly around the lips but also in the hands and feet. Fourteen hours after the ingestion of the tablets she noted an irregular and forceful pounding of the heart which was aggravated by minimal exertion.

### Past History

There was no history of serious organic disease or of rheumatic fever, scarlet fever or syphilis. There was a long history of emotional instability with two divorces and three marriages in the previous fifteen years. She had made several superficial

attempts at suicide by the ingestion of various sedatives and on one occasion by slashing her wrists. None of the attempts had been serious enough to require hospitalization. She smoked 1½ packs of cigarettes a day for fifteen years and admitted to 8-9 quarts of beer and 12-16 oz. of whisky a week.

### Review of Systems

There was no history of dyspnea, orthopnea, palpitations, paroxysmal nocturnal dyspnea, or edema. She denied chest pain. The remainder of the history was negative except for several episodes of hemorrhagic cystitis since the age of thirteen. The family history was noncontributory.

### Physical Examination

The patient was a well-developed, well-nourished, depressed female of approximately her stated age who was complaining of nausea. Temperature: 96°. Blood pressure: 115/90. Pulse: 52 and irregular. The skin was warm, dry and clear. The head and neck were negative except for mild periorbital edema and injection of the conjunctivae. The fundi and pupils were normal. The pharynx, ears and thyroid were normal and the lungs were clear. On examination of the heart the apical impulse was 9.5 cm. to the left of the mid-sternal line in the fifth interspace. There was a predominantly irregular slow rhythm with frequent premature beats occurring in short runs of 2-3 beats. The first sound at the apex was slurred but no murmurs were audible. The second aortic sound was greater than the second pulmonic sound. The abdomen was negative. Neurological examination and the examination of the pelvis and rectum were normal. A complete blood count, urinalysis, blood sugar and NPN were normal. The electrolytes were normal on admission, but the serum-potassium fell from an initial 3.9 meq/L to 3.2 meq/L the day after admission. Despite the administration of 4.0 grams of potassium chloride daily and moderate amounts of orange juice the serum potassium was 3.0 meq/L on September 25 and 3.4 meq/L on September 26. Thereafter the level returned to normal.

A chest X ray was normal except for minimal pleural scarring at the left base. The electrocardiogram showed the following serial changes:

September 22: Ventricular rate: 45-100 averaging 70 min. There was a generally irregular rhythm



due to wandering of the atrial pacemaker, periods of sinus arrest with nodal escape, and premature nodal beats. In addition there were the ST and T changes of digitalis effect and shortening of the QT Interval. (Fig. 1)

September 23. Rate 76. 1° heart block, ST and T changes and mild irregularity due to wandering of atrial pacemaker were present. (Fig. 2)

September 25. Rate 82. The PR Interval was 0.19 and the ST and T changes persisted. (Fig. 3)

September 30. Rate 78. The PR Interval was 0.17 and ST and T changes of digitalis effect were still present. (Fig. 4)

October 11. The electrocardiogram was completely normal.

Initial therapy consisted of pronestyl 200 mgm. IM q 4 h in an attempt to control the ventricular arrhythmia; sparine 50 mgm. I M q 4 h to control the nausea and vomiting; and intravenous saline and potassium chloride. The nausea and vomiting improved within six hours and ceased within eighteen hours after admission. The premature ventricular beats disappeared within eight hours and the sinus arrhythmia disappeared within seventy-two hours. After subsidence of the nausea and

vomiting she was placed on a low carbohydrate diet (C 125, P 100 and F 80), potassium chloride gr x q 4 h, and orange juice.

### Discussion

On admission to the hospital the patient manifested several of the cardinal signs and symptoms of digitalis intoxication, namely nausea, vomiting, paresthesiae, and a slow predominantly irregular rhythm with frequent premature beats occurring in short runs of 2-3 beats. The electrocardiogram revealed a varying rhythm with a wandering atrial pacemaker, short periods of sinus arrest with nodal escape, and frequent premature ventricular beats. ST, QT, and T wave changes characteristic of digitalis were also plainly evident. Surprisingly, in view of the long duration of action of digitoxin, the electrocardiogram two days after the ingestion of digitalis and one day after institution of therapy revealed only 1° heart block and wandering of the atrial pacemaker in addition to the ST, QT, and T wave changes expected after digitalization. The arrhythmia had cleared completely three days after admission and the electrocardiogram had reverted to normal twenty days later.

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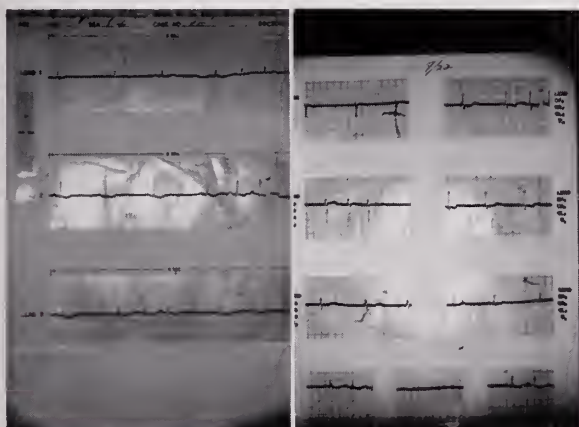


FIGURE 1

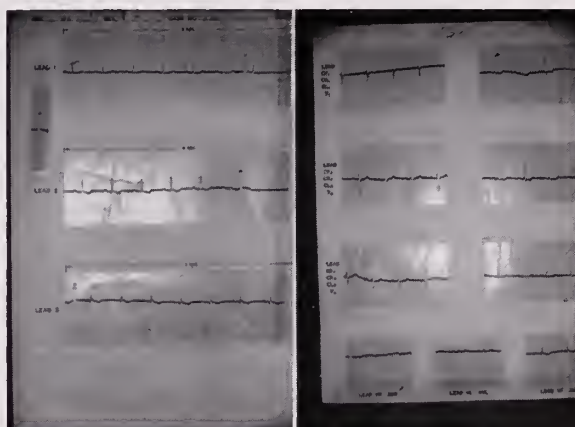


FIGURE 3

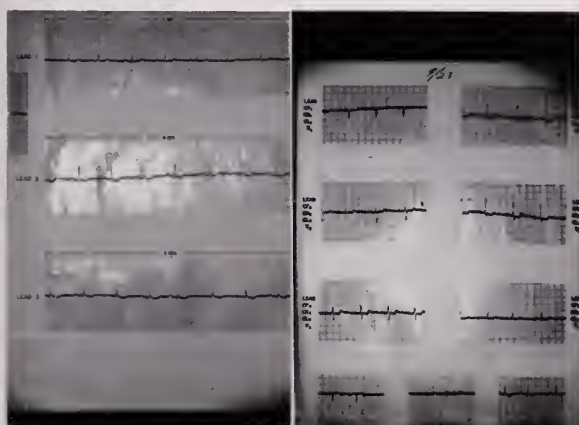


FIGURE 2

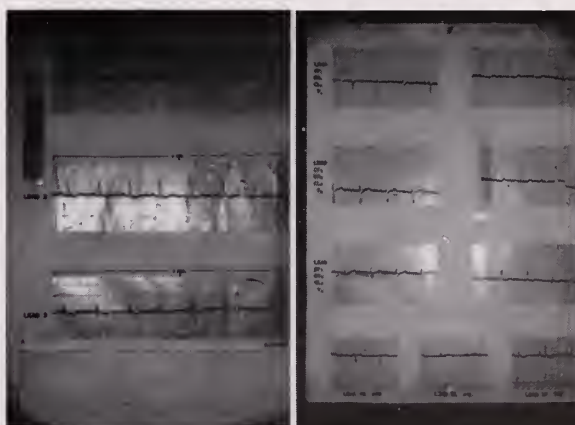


FIGURE 4



The inter-relationship between digitalis intoxication and hypokalemia has been well documented by Sampson et al<sup>2</sup> and by Lown et al<sup>3</sup> and is now widely accepted. The relationship between digitalis intoxication and carbohydrate ingestion was well demonstrated by Page, who was able, by carbohydrate administration, to repeatedly induce ventricular arrhythmias in a group of seven patients who were at, or near, the point of digitalis intoxication.<sup>4</sup>

Insulin produced hypoglycemia is frequently associated with hypokalemia and the characteristic electrocardiographic changes of hypopotassemia (T-Wave inversion and QT Interval prolongation). Parrish et al corrected these electrocardiographic changes by the administration of potassium alone.<sup>5</sup> Lown et al precipitated digitalis intoxication by the administration of glucose and insulin and observed that concomitantly with the appearance of the arrhythmia the serum potassium fell from 4.1 to 3.0. Administration of potassium acetate corrected the cardiac manifestations of digitalis intoxication and the serum potassium changes without affecting the serum glucose concentration. These observations strongly suggest that digitalis intoxication occurring after carbohydrate ingestion is not related to changes in the blood sugar level *per se*, but rather is related to the hypokalemia which occurs when potassium moves into the hepatic cells as glycogen is deposited.

In view of the above clinical and experimental findings the patient was placed on a low carbohydrate diet with supplementary potassium chloride. Pronestyl was given in an effort to control the frequent premature beats and to prevent the development of a serious ventricular arrhythmia. Although it is difficult to evaluate the role of any of the therapeutic measures, the rapid improvement in the electrocardiographic and clinical picture, despite the long duration of action of digitoxin, suggests that the treatment was beneficial.

#### SUMMARY

A case of acute massive digitoxin intoxication is reported. The patient exhibited the classical clinical signs of digitalis intoxication and the electrocardiogram revealed a wandering atrial pacemaker, sinus arrest with nodal escape and frequent premature nodal beats. The signs and symptoms cleared within four days after the institution of therapy with pronestyl, potassium chloride, and a low carbohydrate diet.

#### BIBLIOGRAPHY

- <sup>1</sup>Bergy, G. G.; Fergus, E. B.; and Bruce, R. A.: Acute massive digitoxin poisoning: A report of a case and review of the literature, *Ann. Int. Med.*, 46:964, 1957
- <sup>2</sup>Sampson, J. J.; Alberton, E. C.; and Kondo, B.: Effect on man of potassium administration in relation to digitalis glycosides, with special reference to blood serum potas-

sium, electrocardiogram and ectopic beats, *Am. Heart Journal*, 26:164, 1943

<sup>3</sup>Lown, B.; Salzberg, H.; Enselberg, C. D.; and Weston, R. E.: Interrelation between potassium metabolism and digitalis toxicity in heart failure. *Proc. Soc. Exper. Biol. and Med.*, 76:797, 1951

<sup>4</sup>Page, Ernest: Precipitation of ventricular arrhythmias due to digitalis by carbohydrate administration. *Am. Journal of Medicine*, 29, 2, 169, 1955

<sup>5</sup>Parrish, A. E.; Sugar, S. J. N.; and Fazehas, J.: Relationship between electrocardiographic changes and hypokalemia in insulin induced hypoglycemia. *Heart Journal*, 43:815, 1952

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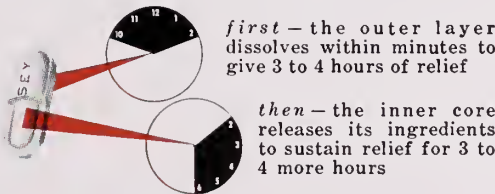
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References: 1. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Bonica, J. J.: in Drugs of Choice, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in Current Therapy, Saunders, Phila., 1958, p.78. 6. Bickerman, H. A.: in Drugs of Choice, Mosby, St. Louis, 1958, p.547.

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## THE FETICH OF DISINFECTION\*

CHARLES VALUE CHAPIN, M.D.

DISINFECTION in this connection refers to that sort which is commonly carried out by health officials after death, or recovery, from contagious diseases. The paper has no reference to that continuous attention to cleanliness — "medical antiseptics" the French call it — which is desirable in the management of contagious cases. This terminal disinfection, if one may so call it, occupies a high place in public sanitation. A reader of works on hygiene would conclude that disinfection is held in equal esteem with isolation, or is perhaps of even more importance, for it is sometimes expected to work wonders in the prevention of disease where there has been no isolation as, for instance, the official disinfection after a case of tuberculosis when for years there may have been no attempt on the part of the patient to prevent the infection of others.

Official disinfection costs money and is annoying. Its only excuse is that it is believed to be an important factor in preventing disease. But is it an important factor, and is its practice based on good evidence of its necessity and value? It is to be feared that it is not. We disinfect not because the utility of the process has been demonstrated, but because of precedent and authority. There can be little doubt that disinfection had its origin at a time when disease was believed to be the work of demons. Burnt sacrifices and fumigations with aromatics were among the means employed to appease the supernatural powers. The early practice of medicine was confined to the priesthood, and the final cleansing of the sick was largely a religious ceremony. This cult of purification by fire and smoke and libations has continued even to modern times. The attempt to give it a scientific basis is an afterthought.

Several arguments are advanced by the advocates of disinfection in support of the practice. Disinfection is necessary, it is claimed, because the virus of the disease becomes attached to material things, such as clothing, books, toys, furniture, and the walls and woodwork of rooms. On these things, it is said, it retains its life for weeks and months,

and these infected things are, therefore, a very important factor in the extension of the contagious diseases.

That this is so is believed because numerous cases are on record in which infected things are assumed to have caused sickness. Now, just here, I wish to make myself perfectly clear. I would not, in the present state of our knowledge, for a moment deny that clothing, books, and even a room itself may be infected and may remain so for a considerable time, and then give rise to a fresh outbreak of disease. What I do claim is that reports of such modes of infection are rarely well authenticated, and even if it is admitted that such infection occasionally takes place, there is no evidence that this is a factor of any moment in the extension of the contagious diseases, while there is a great deal of evidence that it is a factor of no consequence at all.

In most of the cases of alleged infection by fomites the fact is not proven at all; at best it is a possibility merely, not even a probability, and certainly far from a demonstration. The majority of cases of contagious disease cannot be traced with certainty to their origin. Because a certain case develops soon after exposure to a supposedly infected article is no proof that it was due to such exposure. As will be shown later, direct exposure to infected persons is the probable source of the infection in most cases of contagious disease. Unless the source of the infection can be fairly well excluded, it is merely an assumption to attribute the infection to things. A more critical examination of these cases would eliminate most of their value as evidence. After all, instances of apparent infection by fomites are rare. In my own experience of twenty-two years as health officer, I have met with few of them, even in the earlier years of my practice, when I must confess I looked for them more carefully than I do now, since I have become satisfied of their unimportance. Doubtless all health officers will agree with me as to the rarity of cases in which it appears probable that fomites are the source of infection. Certainly no one could develop by induction, from their frequency, the theory that the contagious diseases extend chiefly in this way. It will not be claimed that

\*An address to the American Medical Association, at Boston, Massachusetts, June, 1906. First published in the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 47:574-577, August 25, 1908.





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## THE FETICH OF DISINFECTION

*continued from page 596*

the health officer practices disinfection because compelled to it by the frequency with which cases of fomites infection are brought to his notice. It is done for other reasons.

Probably one reason why so much importance is attached to *thing* infection is the large amount of discussion which is given to the question of the viability of bacteria outside the body. Everybody has heard that anthrax and tetanus spores live for years, and though it is generally recognized that most of the common disease germs do not belong to the spore-forming class, the great vitality of these exceptional types has had its psychologic effect. Bacteriologists have been very apt to report instances of maximum vitality of the organisms of pneumonia, diphtheria, plague, and the like, but it is generally forgotten that these are the exceptions, and the impression remains that most of the bacteria given off from the sick retain their vitality and virulence for a long time, which is certainly not the fact.

But undoubtedly there is another and chief reason why the belief has become so well established that the virus of disease remains long attached to things, that these fomites are a most important source of infection, and that the contagious diseases can only be successfully combated by ter-

minal disinfection. As was before stated, it has rarely been possible to trace more than a small proportion of cases of contagious disease to direct contact with others. Even in country places, cases are constantly appearing without any visible connection with a previous case. In cities it is still more difficult to trace direct exposure to the sick and, so far as can be determined by routine examination, the majority of cases of scarlet fever and diphtheria appear to arise spontaneously, or sporadically, as it was formerly called. Even in smallpox, which owing to its marked eruption and comparative rarity is easier to trace than almost any other disease, a large portion of cases appear to have no connection with previous cases. To explain the origin of these cases has been the chief problem of sanitary science. At one time it was believed by many that the virus of most of the contagious diseases could develop outside of the body; hence, the filth theory of disease which, although now entirely discredited, still has great influence, even among sanitary officials.

The hypothesis which next appealed to workers in this field was that the specific virus, though incapable of growing outside of the body, could yet retain its vitality for a considerable time and, attached to various articles, be carried unnoticed to great distances. It must be admitted that this is a very natural and reasonable hypothesis, and is supported by many of the findings of bacteriology and by certain clinical observations. A dozen years ago it was really the only working theory that we had. Of course, if its probability is admitted, disinfection must necessarily follow. This, I take it, is the true reason why for so many centuries disinfection has played such an important part in preventive medicine. It was the only means for controlling that mode of infection which appeared to be the principal factor in the maintenance of the contagious diseases.

Disinfection had its origin in superstition, and its practice so partakes of the character of magic art that it catches the popular fancy. Even if the health officer does not disinfect, the infected family is quite likely to sprinkle a little sulphur on the stove, or place a saucer of chloride of lime behind the door. Thus unconsciously do we follow the customs of our remote ancestors who exorcised the demon of disease with incense and incantation. Here we have another explanation of the vogue of disinfection.

Let us now examine into the principal scientific argument in favor of disinfection, i.e., *that infection is spread chiefly by things*. As was before stated, this theory was the outcome of the attempt to explain the origin of that vast number of cases of contagious disease which could not otherwise be accounted for. But within the last dozen years

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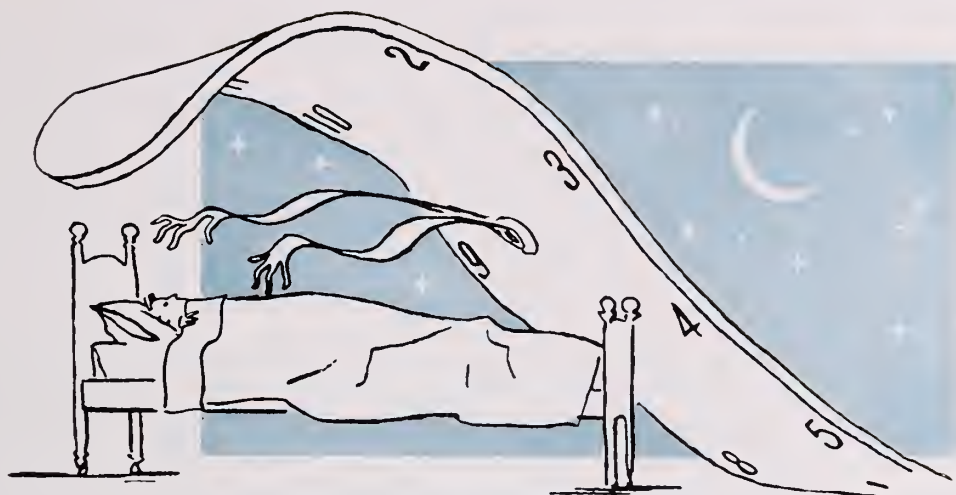
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\*Ethan Allen Brown, N.E. J. Med., 223:843.

F. K. Albrecht, Mod. Mgmt. Clin. Med., P674,  
Williams & Wilkins.

F. W. Wittich, J. Am. Ger. Soc., 3:239, 1955

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*continued from page 598*

a multitude of facts have come to light which renders this theory unnecessary. It has always been recognized that mild and atypical cases of contagious disease are occasionally seen. Scarlet fever without eruption, mild sore throat diphtheritic in nature, and walking cases of typhoid fever were mentioned by the older writers; but they were not believed to be common, and little account is taken of them in the textbooks. Today the majority of physicians are skeptical about the diagnosis when they see an almost afebrile scarlet fever with slight, fleeting rash, or diphtheria without exudation and the patient not confined to the bed; yet those who have studied these diseases most closely, know that the mild atypical cases are extremely common. Even in smallpox a disease with more characteristic symptoms than any other, mild unrecognized cases are very numerous. If one examines the reports of health officers of the past few years, it will be found that the frequency of these mild cases is dwelt on, and to them is attributed the origin and maintenance of most of the local outbreaks. The report on typhoid fever during the Spanish war indicated that mild unrecognized cases were twice as numerous as the recognized cases. In investigating this disease in a small rural community, Koch found scores of cases which the attending physicians failed to recognize, or to which no physician was called. Instance after instance is recorded in which a mild sore throat has been the starting point of an outbreak of diphtheria. In Hartford, of 2,038 apparently benign sore throats found in children at school, 29 per cent were shown to be true diphtheria. The English, who often isolate as high as 90 per cent of their recognized scarlet fever cases in hospitals, and nevertheless continue to have as much of this disease as we do, attribute their failure to control the disease to the existence of so many mild unrecognized cases. We now know that there is a vast number of atypical, unrecognized cases

of contagious disease, sometimes exceeding in number the known cases.

We have learned that there is still another factor to be reckoned with. It is now well known that the pathogenic bacteria often grow in human beings without producing any symptoms of the disease. After recovery, the specific bacteria may continue to develop for weeks, months, and even years. Not only that, but they are found also in persons who have never been sick at all. These are what are called carrier cases and present no symptoms. They are even more numerous than the mild cases of illness. Such carriers have been found for diphtheria, influenza, cerebrospinal meningitis, typhoid fever, cholera, the plague, and many other diseases, and the wide distribution of the pneumococcus is known to everybody. In the protozoan diseases, as malaria, trypanosome diseases, and Texas cattle-fever, individuals often carry the infection in the blood and show no symptoms. These facts receive scant recognition in most textbooks, even those on bacteriology, and are entirely ignored by nearly all writers and lecturers on clinical medicine and sanitation, yet they are of the utmost significance. In mild cases and with living carriers we have the real source of contagious disease.

This whole question may be summed up very concisely. Which is the more likely to be the chief factor in the extension of contagious disease: inanimate objects hypothetically infected with dying bacteria, or living and moving human beings who are continuously throwing off living bacteria? It must be admitted that fomites may occasionally spread disease; but, if we reflect how unlikely infected things are to be brought in contact with people and how great the chance of human beings coming in contact with each other, it seems very unlikely that fomites can have appreciable effect in the spread of disease.

If then, as all evidence tends to show, contagious diseases usually extend by means of pretty direct contact between the infected and the noninfected and transmission by fomites has little influence on such extension, it follows that even the most thorough disinfection will have little effect in checking these diseases. There is certainly no rational basis for making it such an important feature in public health work, and holding it of equal value with isolation.

Another thing to be borne in mind in connection with this subject is that a good deal of disinfection does not disinfect.

It may be asked: What objection can there be to disinfection even if it is not so important as has been thought? Aside from the question of expense, which is by no means unimportant, there is a decided objection. The confidence which the public has in the efficacy of disinfection is the greatest



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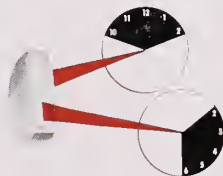
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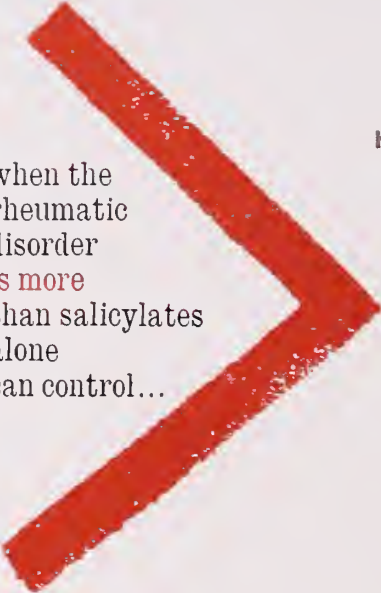
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## DISTRICT MEDICAL SOCIETY MEETINGS

### WASHINGTON COUNTY MEDICAL SOCIETY

The quarterly meeting of the Washington County Medical Society was held at the Larchwood Inn, Wakefield, Rhode Island, on 8 April, 1959. The meeting was called to order by the president, Doctor Menzies, at 11:00 A.M.

The following members were present: Doctors Agnelli, Burbelo, Capalbo, Celestino, Cerrito, De-wees, Eckel, Hathaway, Jones, Manganaro, McGrath, Menzies, Morrone, MacIver, Masyk, Murray, Nathans, Phelan, Robinson, Ruisi, Spicer, Tang, Turco, Walsh, Tatum.

Two members deceased since last meeting, Doctor Henry B. Potter, of Wakefield, and Doctor Arthur Roberge of Quonset Naval Station.

**UNFINISHED BUSINESS:** The subject of listing in the telephone book was discussed by the executive committee. The committee suggested to the Society that the listings by specialty was permitted providing the specialty was one of those listed by the Rhode Island Medical Society. The executive committee disapproved of listings in telephone books other than those that serve the community in which the physician is practicing as this would institute advertising. It was brought up that there are a few cases in which cross listing is necessary because the physician is actually practicing in both communities. In view of this a motion was made by Doctor McGrath and seconded by Doctor Cerrito that the president of the Society look into the selected cases in which more than one listing is necessary and that the president be granted the power to permit this listing in selected cases when he deems necessary. This motion was carried. There was no motion on the question of listing by specialty but the discussion revealed that the consensus was that listing by specialty be permitted providing the physician is listed as a specialist in the Rhode Island Medical Society list. This listing is the *Roster of Members* of the Rhode Island Medical Society issued in January, 1958.

Under unfinished business the question of a questionnaire that was sent to the members of the Society concerning the problem of emotionally disturbed and mentally retarded children was discussed and the members were asked to send in the questionnaires they receive and so help the Society

to evaluate the problem in this community.

The application of Doctor MacIver was unanimously approved and Doctor MacIver was appointed to the Washington County Medical Society. Doctor Tatum reported on the financial status of the Society.

Bills before the House and Senate were discussed and the Society was in agreement with the Rhode Island Medical Society concerning all of these bills.

A bill, S343, which in effect would exempt physicians from jury duty was roundly discussed. It is the opinion of the House judiciary committee that physicians should serve as jurors and with the exception of one or two members of the Washington County Medical Society it was the opinion of this body that physicians should serve as jurors whenever they are called.

The question of publicity in the form of news releases under the Washington County Medical Society concerning polio immunization was discussed. A motion was made by Doctor Agnelli that the Washington County Medical Society pay for advertisements concerning this, but the motion was not seconded and the feeling of the Society was that news releases be given to the newspapers and radio by the officers of the Society urging that all individuals be immunized and that booster shots be also urged when recommended by the family physician.

A motion was made by Doctor Agnelli and seconded by Doctor Cerrito to adjourn.

Scientific section: Doctor Russell R. Hunt spoke on *The Problem of Radiation*.

Respectfully submitted,

FREEMAN B. AGNELLI, M.D., *Secretary, pro tem*

### KENT COUNTY MEDICAL SOCIETY

The meeting of the Kent County Medical Society was called to order at 9:10 p.m. on March 24, 1959, at Kent County Memorial Hospital. A symposium on *Cardiac Catheterization and Angiocardiography* was presented by Lester Vargas, M.D.; Frank Merlino, M.D., and Thomas Forsythe, M.D. Rapid strides in cardiac surgery have made accurate diagnosis important. The technique, evaluation, and X-ray findings of cardiac catheterization and angiocardiography in cases of congenital heart disease

*concluded on page 608*

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## KENT COUNTY MEDICAL SOCIETY

*concluded from page 606*

were well presented and illustrated.

Thirty-five members and guests were present. Minutes of the December 10, 1958, meeting were read and approved. The committee reported that the cost of a trunk line for a Kent County phone answering service would be prohibitive. The Valley Answering Service was reported to have improved its service. Doctor O'Hanian moved that the secretary ascertain from the Rhode Island Medical Society the policy regarding appointing an advisory committee to the National Foundation or any other such "health foundation or society." The motion was seconded by Doctor Merrill, and following general discussion, was passed.

Doctor Hardy suggested that if no notice were sent by the state Society regarding the Benevolence Fund, that a notice should be sent to all members of our society advising a donation.

Doctor Merrill polled the membership of the Kent County Medical Society as follows: Do you favor M.D.'s being able to be under Social Security? Yes 38. Plus 2 qualified Yes 40. No 14. Plus 1 qualified No 15.

Doctor Merrill then moved that:

(1.) The delegates of the Kent County Medical Society be instructed to request that the Rhode Island Medical Society be polled on the following question:

Should the United States Congress pass legislation to include Doctors of Medicine in Social Security? Yes or No?

(2.) That the delegates to the A.M.A. from the Rhode Island Medical Society be instructed to raise the question at the A.M.A. meeting and vote there according to the wishes of the majority in the state poll.

The motion was seconded by Doctor Erinakes and passed unanimously.

There was a discussion regarding increasing attendance at meetings by having 4:00 P.M. meetings and dinner meetings.

A committee to arrange the annual clambake for the June meeting was appointed as follows: Jean Maynard, M.D., Peter Koch, M.D., and Joseph Wittig, M.D.

The meeting was then adjourned.

Respectfully submitted,

RUSSELL P. HAGER, M.D., *Secretary*

**Monday, October 5 at 8:30 P.M.**

***Providence Medical Association  
Meeting***





## *“Daddy, What’s Penicillin?”*

“What’s penicillin?” There, in two words, is the merest hint of a tremendously exciting story — the advances in modern medicine.

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For instance, delicate operations on the heart muscle — unheard of a few years ago — are now an established fact — opening up new hope for many who a short time ago could not be helped.

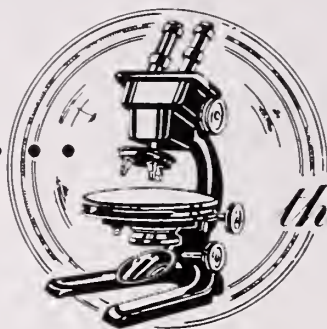
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THROUGH .

*the Microscope****A.M.A. Members to Get Four Publications***

As the result of approval by the A.M.A. House of Delegates, each A.M.A. member will now get TODAY'S HEALTH in addition to the JOURNAL OF THE A.M.A., a specialty journal of the member's choice, and the bimonthly A.M.A. NEWS.

Every doctor will get a direct mailing from Chicago making inquiry as to the specialty journal he wishes to have in addition to the JOURNAL OF THE A.M.A. Until now the member had his choice of either the journal or a specialty publication. The new ruling gives him both.

The ten optional specialty publications are the Archives of: Internal Medicine, Dermatology, Neurology, General Psychiatry, Pathology, Surgery, Otolaryngology, Ophthalmology, and Industrial Health, and the Journal of Diseases of Children.

***R. I. Neurological Society Affiliates with American Psychiatric Association***

During the summer the Rhode Island Neurological Society voted to become a district branch of the American Psychiatric Association. New officers of the branch are Dr. Melvin Johnson, president; Dr. David Fish, vice president; Dr. Robert Hyde, secretary, and Dr. Sidney Goldstein and Dr. Laurence Senseman, councillors. The Rhode Island Neurological Society will by this action function as a parallel organization with the already existing district branch of the A.P.A.

***Rhode Island Host to New England Medical Librarians***

The New England Regional Group of Medical Librarians will meet at the Library of the Rhode Island Medical Society on October 30 and 31. A luncheon session on the 30th will be followed by an afternoon of lectures, and then a banquet in the evening. A workshop program and business meeting is scheduled for Saturday morning. The meeting will mark the first time the group has met at the Medical Library here.

***Use of Local Hospitals Ruled by Health Department***

Doctor Jeremiah A. Dailey, state director of health, issued a ruling this summer that medically indigent patients cannot be referred to hospitals outside the state for treatment, without authorization from the Department of Health. If the facilities for treatment are available in Rhode Island these patients must be referred to local hospitals if payment is to be made by the Department, Doctor Dailey reported. If there is an exceptional case which cannot be treated locally, the physician must receive authorization from the Department before referring the patient out of state.

***New Englanders in Medical Schools***

New England as a region is below the national average in the number of its residents entering medical schools.

This fact is revealed in a study recently conducted by the New England Board of Higher Education which compares the average ratio of students per 100,000 population from each state entering medical schools from 1948 to 1958.

Of the six states in the region, only Vermont exceeds the national average of students entering medical schools and it ranks fourth in the nation. It is the only state in New England with a publicly supported medical school.

Connecticut, which ranks nineteenth in the country, is at the national average. Massachusetts is twenty-ninth, Rhode Island thirty-seventh, New Hampshire forty-second, and Maine forty-seventh.

*continued on page 612*

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Xylocaine Ointment, a surface or topical anesthetic, gives fast, effective and long lasting relief. Its *water-soluble, nonstaining* base melts on contact with the skin, to assure immediate release of the anesthetic for fast action and it does not interfere with the healing processes.



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**Matching Gifts for Hospitals Program**

A *Matching Gifts for Hospitals* program, believed to be the first of its kind, has been established by the Smith Kline & French Foundation.

Under the program, the Foundation will match — up to \$2,000 — the contributions to accredited hospitals by employees of Smith Kline & French Laboratories, Philadelphia pharmaceutical firm. The plan parallels the Foundation's *Matching Gifts for Education* program which was established in 1956, and which has brought \$98,760 to accredited colleges, universities and independent secondary schools since its inception.

In order for hospitals to receive support under the program, they must be accredited by the Joint Commission on Accreditation of Hospitals and must be located within the United States or its possessions. No distinction is made between privately endowed or tax supported hospitals, except that the institution must be one to which contributions are deductible under the Internal Revenue Code.

Recipients may use contributions for augmenting required capital and general operating funds, providing expanded medical and surgical care for the treatment and maintenance of the sick and injured, increasing medical facilities and equipment, and improving incentives for the highest quality of professional medical care.

**A.M.A. Declares Warnings Needed on All Hazardous Chemicals**

Warnings on the labels of all products containing hazardous chemicals was declared today as the objective of a model law formulated by the American Medical Association and recently introduced into Congress (H.R. 7352).

Speaking before the Association of Food and Drug Officials of the United States, in Boston, Bernard E. Conley, Ph.D., Chicago, secretary of the A.M.A. Committee on Toxicology, declared "If we are to educate people to read labels and obey their warnings, we must require identification of hazardous ingredients on all products, not merely on certain classes of chemicals such as pesticides."

Half of all substances causing accidental injury and death are not required by law to carry precautionary labeling. Many of these are used in the home, in small businesses and in other areas where control of harmful exposures is not as guarded as in the manufacturing process.

While three quarters of these products contain substances which are moderately toxic or worse, most states and the federal government have no laws to require them to carry warnings or to declare toxic or other hazardous constituents. Dr. Conley declared.

There has been a growing acceptance of the need to label hazardous household chemicals. Examination of over 1,000 varieties of products revealed that chemicals used in commercial establishments, such as hotels, garages, laundries and restaurants, need the benefit of labeling as greatly as those entering the home.

Dr. Conley discounted the claim that wide use of precautionary labeling would bring about eventual disregard of all warnings. The widespread use of danger and warning signs for transportation and traffic hazards has never been considered a deterrent to safety. No one ever suggested that our mounting motor accident statistics are due to the number of safety signs about them; rather the growing number of auto accidents is related to the increasing number of motor vehicles. The same basic factors underlie the problem of accidental poisoning by hazardous chemicals.

**Foreign Student Total in America Up 38% in Five Years**

The number of foreign students studying in the United States has increased 38% in the last five years, the Institute of International Education reported in a survey released recently.

The 47,245 students from 131 countries registered in U.S. colleges and universities this year represent a 9% increase over the number last year and an 86% increase over that of the academic year 1948-49. According to all available statistics the current figure represents the largest foreign student population in any country of the world.



provides therapeutic levels . . . for 24 hours . . . with low incidence of sensitivity reactions . . .

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The postwar period has also produced a great spurt in the exchange of university teachers and scholars, the Institute revealed in its fifth edition of *Open Doors*, an annual statistical report on educational exchange. In five years, the number of foreign professors teaching in our schools has tripled. American colleges and universities reported 1,937 foreign faculty members this year, in comparison to 635 in 1954-55. With 1,842 American faculty abroad, this was the first year on record that we "imported" more professors than we "exported."

The *Open Doors* survey on foreign physicians showed a new high of 8,392 doctors from 91 countries in training here this year—an increase of 10% over last year and 65% over five years ago. The Far East again sent the largest number, with the Middle East showing the greatest increase—25% more doctors than last year.

### THE FETICH OF DISINFECTION

*concluded from page 602*

hindrance to the development of better methods of handling disease and guarding against infection. To practice strict personal cleanliness, not only in the presence of contagious disease but at all times, is the sole mode now known by which the unrecognized cases and the carrier cases can be guarded against. The public, and even the medical

profession, refuse to believe in infection in well persons, but cling to the old notion that it is things, not persons, that are to be feared. And they will cling to this view so long as health officials lay so much stress on their official disinfection. Many a time a family has lived for months with a consumptive who has taken no precautions about his sputum, and after his death has promptly asked to have the house fumigated. The expiatory sacrifice of disinfection is believed to atone for every sanitary sin. It is our duty to teach that hygienic salvation can only be attained through the good works of personal cleanliness. As the surgeons have given up antisepsis for asepsis, so the health officer must substitute cleanliness for disinfection.

### KAPOSI'S SARCOMA

*concluded from page 591*

<sup>6</sup>Philippon, L.: Ueber das Kaposi idiopathicum cutis Kaposi: ein beitrage zur sarcomlehre. Virchows Arch. f. path. Anat., 167:58, 1902

<sup>7</sup>Babes, V.: In Ziemssen's Handbook der speziellen Pathologie und Therapie. Leipzig, F.C.W. Vogel, 1884, vol. 14, part 2, p. 473

<sup>8</sup>MacKee, G. M. and Cipollaro, A. C.: Idiopathic multiple hemorrhagic sarcoma (Kaposi). Am. J. Cancer, 26:1, 1936

<sup>9</sup>Ronchese, F. and Kern, A. B.: Lymphangioma-like Tumors in Kaposi's Sarcoma, A.M.A. Arch. Dermat. & Syph. 75:418-427, (March) 1957

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Phenobarbital (¼ gr.) . . . . .	16.2 mg.
Hyoscyamine Sulfate . . . . .	0.031 mg.
<b>plus</b>	
Prophepyridamine Maleate . . . . .	12.5 mg.
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## BOOK REVIEWS

*YOUR MIND CAN MAKE YOU SICK OR WELL* by Curt S. Wachtel, M.D. Prentice-Hall, Inc., Englewood Cliffs, N.J., 1959. \$4.95

Dr. Wachtel's book deals, as many others do, with difficulties in the psychosomatic field. He uses his forty years' experience with patients for the education of the layman, or, what he calls "the man in the street." Accurate observations, a keen sense of humor and a smooth conversational tone make for easy reading.

The author's self-treatment is based on the use of the well-known *life chart*, in which the patient correlates his age, education, significant life situations, illnesses, accidents, etc., with his physical complaints. This process is supposed to help him with the realization of motives for his complaints.

The book may be helpful to a few psychoneurotics, but, in my experience, the general bulk of patients of this type are not relieved of their symptoms by a purely intellectual insight in their problems and require the security of doctor-patient relationship. Doctor Wachtel is well aware of it himself, as he treats some of his patients for years. From the psychiatric point of view I find the book too directive.

I feel that this book may be helpful to a medical doctor in the treatment of hypochondriacal patients by providing him with numerous striking case histories for them and giving him a good insight into the psychological mechanism of conversion and psychophysiologic stress reactions.

C. ZOURABOFF, M.D.

*FUNDAMENTALS OF OTOLARYNGOLOGY*. A Textbook of Ear, Nose and Throat Diseases by Lawrence R. Boies, M.D. W. B. Saunders Company, Phil., 1959. 3rd ed. \$8.00

Here is a new third edition of an already well-known and widely accepted teaching text on the management of ENT problems seen in daily practice. There have been many recent developments in otology, in the fields of hearing conservation and surgical restoration of hearing. Regarding the latter, the use of the operating microscope to mobilize the stapes is discussed. Other new chapters added are those on maxillofacial injury, reconstructive

nasal surgery, tumefaction of the neck, and disorders of the salivary glands. These, like the chapters from the earlier editions, are well illustrated and the material presented in an interesting and concise manner.

This edition is recommended to the nonspecialist in ENT who wishes to keep his library up to date.

FRANCIS L. MCNELIS, M.D.

*HEARING: A HANDBOOK FOR LAYMEN* by Norton Canfield, M.D. Doubleday & Co., Inc., Garden City, N.Y., 1959. \$3.50

Every physician, whether he be general practitioner, pediatrician, internist, otologist, psychiatrist, or surgeon, may have some interest in this book since it portrays so vividly the emotional and physical results of impaired hearing from the cradle to the grave. This book can be read by laymen, and is written for them, but should be read by every practitioner of medicine who wants to understand the problems of the patient who has to put up with impaired hearing.

The chapters on parent-child relationship as well as those on the senior citizen are excellent and typical of the way in which this book has been prepared. The use of artificial aids and an employment of surgery in correcting some of the hearing deficiencies is dealt with, and not the least of all of this is the chapter written for those who live with those impaired. Even the problems of industry are brought up. This is an important concept for the future.

Doctor Canfield has done an excellent job in preparing this book which was written for laymen, but which will be most enjoyed I am sure by doctors.

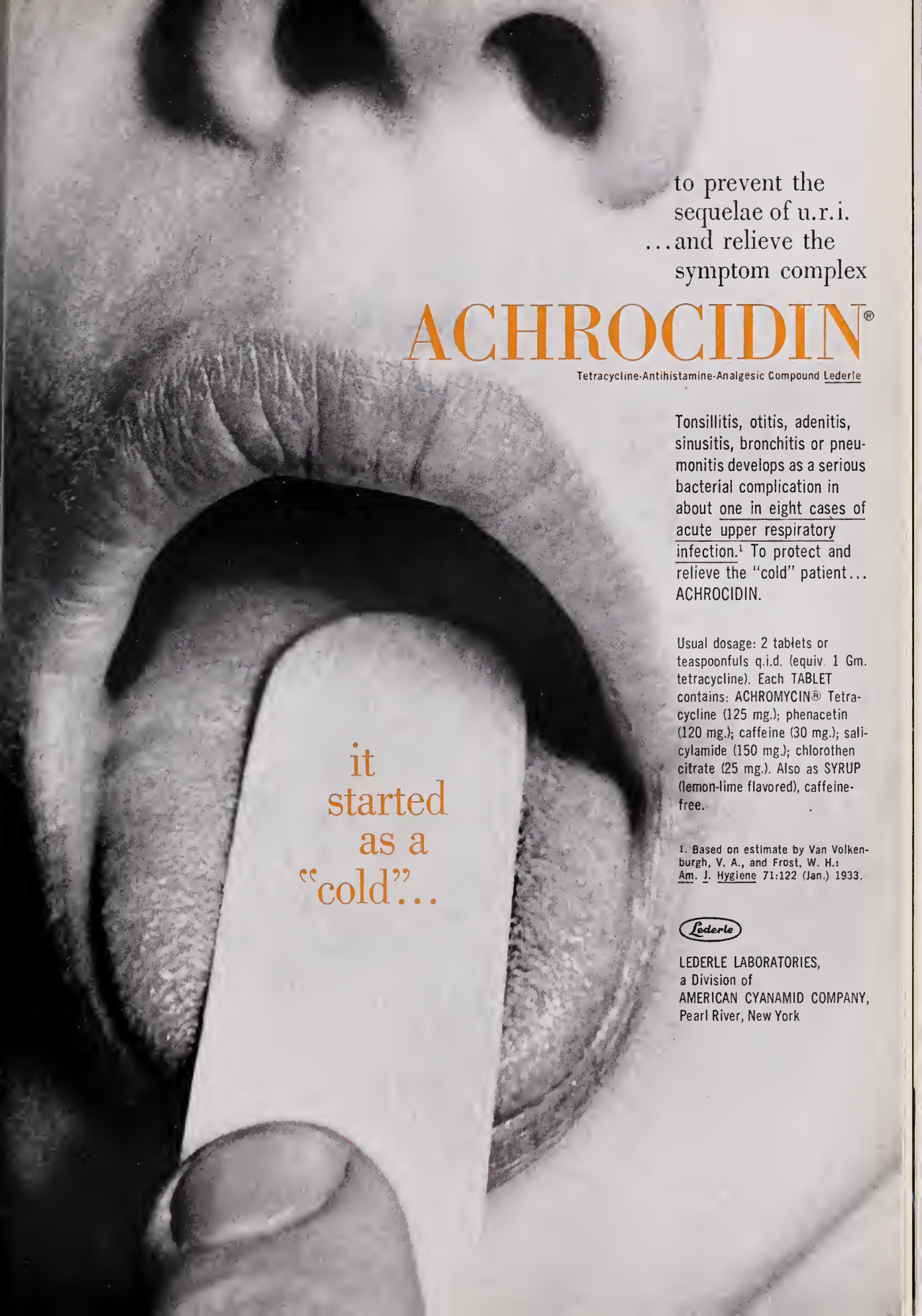
RUDOLPH W. PEARSON, M.D.

*THAT THE PATIENT MAY KNOW*. An Atlas for Use by the Physician in Explaining to the Patient, by Harry F. Dowling and Tom Jones, assisted by Virginia Samter. W. B. Saunders Co., Phil., 1959. \$7.50

This book will help the patient-physician relationship considerably. Decades ago, or even now outside of the United States, the patient would not have dared to insist on so many why's.

*concluded on page 616*





to prevent the  
sequelae of u.r.i.  
...and relieve the  
symptom complex

# ACHROCIDIN<sup>®</sup>

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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933.

it  
started  
as a  
"cold"...



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## BOOK REVIEWS

*concluded from page 614*

Many patients ask for and are entitled to an explanation. They are happy if the physician gives one by showing pictures in textbooks or by writing down complicated names, that cannot be grasped from the spoken words.

Since a diagram is much easier to understand, the book is entirely made up of diagrams. It is intended for the physician's desk in order to make somewhat clearer to the patient the intricacies of normality, pathology and therapy.

The charts on nutrition, metabolism and growth are particularly useful. The technique of insulin injections is well explained. I prefer straight clip-pers to paper-scissors for cutting diabetic nails.

The title is not one hundred per cent clear. It may give the layman the impression of a book of knowledge. Perhaps it would have been better to reverse the title and subtitle.

F. RONCHESE, M.D.

*A DOCTOR DISCUSSES MENOPAUSE* by G. Lombard Kelly. The Budlong Press, Chic., 1959. Patient Price \$1.50

This is a small, concise book which may well be

## RHODE ISLAND MEDICAL JOURNAL

given by doctors to their patients in their forties. If women (and husbands) had the knowledge and understanding to be gained by reading this little book, they would live much happier, better adjusted lives.

Not only are the physical aspects of the menopause explained intelligibly, but, also, the emotional and sexual problems of a woman in her middle forties are discussed.

A few simple pictures and charts such as the reproductive organs and hormones governing them, ovulation temperature charts, exercises for keeping trim and self-examination of the breasts add much to the book's value.

Complimentary desk copies are available to physicians who write on their own stationery to: Budlong Press, 5428 North Virginia Avenue, Chicago 25, Illinois.

MERLE M. POTTER, M.D.

**Wednesday, October 7 at 8:00 P.M.**

***House of Delegates Meeting***

***Rhode Island Medical Society***

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**DATES YOU SHOULD CHECK**

(Mark your calendar now for the dates applicable to you)

*Friday, October 16, and Saturday, October 17*

New England Surgical Society, at Wentworth-by-the-Sea, New Hampshire.

*Saturday, October 17*

Dance. Woman's Auxiliary to Rhode Island Medical Society, Metacomet Country Club.

*Friday, October 23, and Saturday, October 24*

College of Physicians. Northeast and Eastern Canada Regional Meeting, at Providence (Sheraton-Biltmore Hotel).

*Friday, October 30 and Saturday, October 31*

New England Regional meeting, Medical Librarians, at Providence.



## ALBERT H. MILLER—PHYSICIAN

concluded from page 585

- <sup>14</sup>Gas-Oxygen Anesthesia: Indications for Its Use. New York Med. J. 99:181, January 24, 1914
- <sup>15</sup>The Routine Administration of Ether in Measured Dosage. International Clinics, Philadelphia, Vol. 4, Series 24, pp. 250-256, 1914
- <sup>16</sup>Nitrous Oxid-Oxygen Anesthesia: A New Apparatus. J.A.M.A. 63:1474-1475, October 24, 1914
- <sup>17</sup>Mortality Under Anesthetics. American Yearbook of Anesthesia and Analgesia, p. 107, 1915
- <sup>18</sup>Anesthetics of the Future. Providence Medical Journal 17:185, July, 1916
- <sup>19</sup>Nitrous Oxid-Oxygen Anesthesia: With Description of a New Apparatus. Am. J. Surg. 30:7:86-89, July, 1916 (Anesthesia Supplement)
- <sup>20</sup>Proposed Numerical System of Hospital Records. The Modern Hospital 7:3:185, September, 1916
- <sup>21</sup>Anesthetic Records and Statistics of Anesthesia. Am. J. Surg. 31:4:50-54, April, 1917 (Anesthesia Supplement)
- <sup>22</sup>Comparative Study of Blood Pressure in Anesthesia. Am. J. Surg. 31:10:120-122, October, 1917 (Anesthesia Supplement)
- <sup>23</sup>Care of the Eyes of the Patient During Etherization. J.A.M.A. 70:2:83, January 12, 1918
- <sup>24</sup>A New Inhaler for Nitrous Oxid Anesthesia. J.A.M.A. 71:109, July 13, 1918
- <sup>25</sup>The Anesthetist's Day's Work. Am. J. Surg. 32:10:111, October, 1918 (Anesthesia Supplement)
- <sup>26</sup>The Importance of Blood Pressure Observations in Surgical Prognosis. Boston Med. & Surg. J. 180:1:12-15, January 2, 1919
- <sup>27</sup>The Influence of Age in Surgical Prognosis. Am. J. Surg. 33:10:112-114, October, 1919 (Anesthesia Supplement)
- <sup>28</sup>Surgical Shock: Its Relation to Anesthesia. New York Med. J. 110:681, October 25, 1919
- <sup>29</sup>Blood Pressure in Operative Surgery. J.A.M.A. 74:514-516, February 21, 1920
- <sup>30</sup>Some Anesthetic Relations. Am. J. Surg. 34:7:66-69, July, 1920 (Anesthesia Supplement)
- <sup>31</sup>Blood Pressure Guides During Anesthesia and Operation. Pennsylvania Medical Journal 24:6:372-375, March, 1921
- <sup>32</sup>Blood Pressure Guides During Anesthesia and Operation. Am. J. Surg. 35:4:34, April, 1921 (Anesthesia Supplement)
- <sup>33</sup>Anesthetic Units of Measurement. J.A.M.A. 77:433-435, August 6, 1921
- <sup>34</sup>Pharyngeal Insufflation Anesthesia. J.A.M.A. 79:441-443, August 5, 1922
- <sup>35</sup>Methods of Etherization. Anesth. & Analg. 1:4:19, August, 1922
- <sup>36</sup>The Preliminary Examination of Patients Who Are To Undergo Surgical Operations. Anesth. & Analg. 2:4:156-158, August, 1923
- <sup>37</sup>Obstetric Shock. Rhode Island M. J. 6:9:131-136, September, 1923
- <sup>38</sup>Obstetric Shock. Anesth. & Analg. 3:1:23, February, 1924
- <sup>39</sup>A Blood Pressure Paradox. J.A.M.A. 82:1511-1512, May 10, 1924
- <sup>40</sup>Ascending Respiratory Paralysis Under General Anesthesia. J.A.M.A. 84:201-202, January 17, 1925
- <sup>41</sup>Influence of Anesthesia on Respiration. Anesth. & Analg. 4:2:96, April, 1925
- <sup>42</sup>Ideals and Ethics. Rhode Island M. J. 9:2:17-19, February, 1926
- <sup>43</sup>The Influence of Demonstrable Cardiac Lesions on Surgical Prognosis. Anesth. & Analg. 6:1:29-30, February, 1927
- <sup>44</sup>Postoperative Complications: A Comparison Between Ether and Nitrous Oxid in 5,000 Cases. Anesth. & Analg. 6:5:245-247, October, 1927
- <sup>45</sup>Postoperative Complications in 5,000 Cases of Ether and Nitrous Oxide Anesthesia. Rhode Island M. J. 10:12:181-183, December, 1927
- <sup>46</sup>The Origin of the Word *Anesthesia*. Boston Med. & Surg. J. 197:26:1218-1222, December 29, 1927; also Anesth. & Analg. 7:4:240-247, July-August, 1928
- <sup>47</sup>Post-operative Complications. II. Hysterectomy Compared with Appendectomy. Rhode Island M. J. 11:11:173-175, November, 1928
- <sup>48</sup>At the Grave of William T. G. Morton on *Ether Day*. Anesth. & Analg. 8:1:9-10, January-February, 1929
- <sup>49</sup>The Influence of Pharyngeal Anesthesia on Surgical Prognosis. Anesth. & Analg. 8:4:237-240, July-August, 1929
- <sup>50</sup>A Report on Pharyngeal Anesthesia. Rhode Island M. J. 12:11:171-173, November, 1929
- <sup>51</sup>Pre-operative Estimation of Surgical Risk. Rhode Island M. J. 13:6:81-83, June, 1930
- <sup>52</sup>The Pneumatic Institution of Thomas Beddoes at Clifton, 1798. Ann. Med. History 3:3:253-260, May, 1931
- <sup>53</sup>Anesthetics: Their Relative Values and Dangers. Fiske Fund Prize Essay, 1931. Rhode Island M. J. 14:9:5-51, September, 1931
- <sup>54</sup>Resuscitation. Rhode Island M. J. 15:3:39-42, March, 1932
- <sup>55</sup>Inhalation Anesthesia by a Gravitational Method. Anesth. & Analg. 11:2:52-53, March-April, 1932
- <sup>56</sup>A Visit to the Birthplace of William Thomas Green Morton. Anesth. & Analg. 11:3:45, May-June, 1932 (Supplement)
- <sup>57</sup>Constant Positive Pressure Nitrous Oxide Oxygen Anesthesia for Thoracic Surgery. J. Thoracic Surg. 2:3:296-301, February, 1933
- <sup>58</sup>Technic of Oxygen Therapy. Rhode Island M. J. 16:3:38-42, March, 1933
- <sup>59</sup>Thomas Beddoes: Pioneer in Inhalation Therapy. Anesth. & Analg. 12:4:137-144, July-August, 1933
- <sup>60</sup>Organization of the Anesthesia Service of the General Hospital. J.A.M.A. 101:1119-1121, October 7, 1933
- <sup>61</sup>Two Notable Controversies: Over the Invention of the Electric Telegraph and the Discovery of Surgical Anesthesia. Ann. Med. History 6:2:110-123, March, 1934
- <sup>62</sup>Paraldehyde and Other Preliminary Hypnotics. Anesth. & Analg. 15:1:14-21, January-February, 1936
- <sup>63</sup>The Diaphragmatic Respiration Recorded by a Synchronous Pneumograph. Rhode Island M. J. 19:5:59-61, May, 1936
- <sup>64</sup>Surgical Prone Posture. J.A.M.A. 108:185-187, January 16, 1937
- <sup>65</sup>Postoperative Pulmonary Complications. New England J. Med. 216:22:973-976, June 3, 1937
- <sup>66</sup>The Role of Diaphragmatic Breathing in Anesthesia and a Pneumographic Method of Recording. Anesth. & Analg. 17:1:38-43, January-February, 1938
- <sup>67</sup>Posture in Anesthesia. New England J. Med. 218:9:385-386, March 3, 1938
- <sup>68</sup>Anesthesia for the Benefit of the Patient: A Symposium. Rhode Island Med. J. 23:1:1-3, January, 1940
- <sup>69</sup>Usher Parsons, Founder of Rhode Island Hospital. Rhode Island M. J. 23:168-173, October, 1940
- <sup>70</sup>Surgical Posture: With Symbols for Its Record on the Anesthetist's Chart. Anesthesiology 1:3:241-245, November, 1940
- <sup>71</sup>Technical Development of Gas Anesthesia. Anesthesiology 2:4:398-409, July, 1941
- <sup>72</sup>Prelude to Surgical Anesthesia. Connecticut State M. J. 7:3:176-187, March, 1943
- <sup>73</sup>Ether Anesthesia: Yesterday, Today and Tomorrow. Anesthesiology 8:5:471-478, September, 1947
- <sup>74</sup>Anesthesia in Rhode Island. Rhode Island M. J. 31:1:37-41, January, 1948



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DIRECTORY OF MEDICAL SPECIALISTS. Vol. IX, 1959. Marquis—Who's Who, Chic., 1959.  
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Rhode Island Council of Community Services, Inc. — DIRECTORY OF HEALTH, WELFARE, RECREATION AGENCIES IN RHODE ISLAND. Prov., 1959.

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E. A. Spiegel, editor—PROGRESS IN NEUROLOGY AND PSYCHIATRY. Vol. XIII. Grune & Stratton, N.Y., 1958.

SURGICAL FORUM. Proceedings of the Forum Sections. . . . Clinical Congress of the American College of Surgeons, Chicago, Ill. Vol. VI, Chic., 1956; vol. VIII, Chic., 1958.

Carl J. Wiggers — REMINISCENCES AND ADVENTURES IN CIRCULATION RESEARCH. Grune & Stratton, N.Y., 1958.

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*Review volumes from the Rhode Island Medical Journal were:*

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Medical Department, U.S. Army—SURGERY IN WORLD WAR II. Orthopedic Surgery in the Mediterranean Theater of Operations. Office of the Surgeon General, Wash., 1957.

Stanley D. Miroyiannis—501 QUESTIONS AND ANSWERS IN ANATOMY. Vantage Press, N.Y., 1959.

NATO—EMERGENCY WAR SURGERY. U.S. Armed Forces Issue of NATO Handbook. U.S. Government Printing Office, Wash., 1958.

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Harvey Cushing—PAPERS RELATING TO THE PITUITARY BODY, HYPOTHALAMUS AND PARASYMPATHETIC NERVOUS SYSTEM. Springfield, Ill., 1932.

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COMMUNICATIONS DES INVITES ETRANGERS. Congres national des sciences medicales. Bucarest 5-II, Mai 1957. Gift of the Ministerul Sanatatu si Prevederilor Sociale Centrul de Documentare Medicala, Rumania.

Howard F. Conn—CURRENT THERAPY 1956. Gift of Mr. Wallace Maxon.

Council on Drugs — NEW AND NONOFFICIAL DRUGS . . . 1959. J. B. Lippincott Co., Phil., 1959. Gift of the American Medical Association.

Eve Curie—JOURNEY AMONG WARRIORS. Doubleday, Doran & Co., Inc., Garden City, N.Y., 1943. Gift of Miss Grace E. Dickerman.

Benjamin J. Darsky, Nathan Sinai & Solomon J. Axelrod — COMPREHENSIVE MEDICAL SERVICES UNDER VOLUNTARY HEALTH INSURANCE. Harvard University Press, Cambridge, 1958.

DAVID A. TUCKER, JR. LIBRARY OF THE HISTORY OF MEDICINE. A Bibliography. Cinc., 1959. Gift of the Medical College, University of Cincinnati.

Eaton Laboratories — NITROFURAN BIOLOGIC BIBLIOGRAPHY, 1957. Gift of the Laboratories. 2nd copy given by Brown University. Maxwell Finland & others—THE BASIC AND CLINICAL RESEARCH OF THE NEW

ANTIBIOTIC, KANAMYCIN. Ann. N.Y. Acad. Sc. 76:17-408, Sept. 30, 1958. Gift of Bristol Laboratories, Inc.

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THE ANNUAL OF CZECHOSLOVAK MEDICAL LITERATURE. 1956. Praha, 1958. Gift of the National Library of Czechoslovakia.

PROCEEDINGS OF MEDICAL CIVIL DEFENCE CONFERENCE, San Francisco, June 21, 1958. Gift of the American Medical Association. STUDIES FROM ROCKEFELLER INSTITUTE. Reprints, Vol. 157, 1959. Gift of the Institute.

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STUDIA IN HONOREM, N. I. NISSEN. Sexagenarii. Ab Amicis, Collegis Discipulisque Conscripta. 1898-30. 7-1958. Hafniae, 1958. Gift of Brown University Library.

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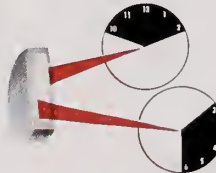
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*Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours*



*first* — the outer layer dissolves within minutes to produce 3 to 4 hours of relief

*then* — the core disintegrates to give 3 to 4 more hours of relief

*Each TRIAMINIC Tablet provides:*  
Phenylpropanolamine HCl .....50 mg.  
Pheniramine maleate .....25 mg.  
Pyrilamine maleate .....25 mg.  
One-half of this formula is in the outer layer, the other half is in the core.

*Dosage:* One tablet in the morning, mid-afternoon and at bedtime.

*References:* 1. Lhotka, F. M.: Illinois M. J. 112: 259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.


**TRIAMINIC JUVELETS:** Each timed-release Juvelet is equivalent in formula and dosage to one-half of a TRIAMINIC tablet, for the adult or child who requires only half strength dosage.

**TRIAMINIC SYRUP** is recommended for adults and children who prefer liquid medication. Each 5 ml. tsp. is equivalent to ¼ of a Triaminic Tablet. *Adults:* 2 tsp. 3-4 times a day; *children 6-12:* 1 tsp. 3-4 times a day; *children under 6:* in proportion.

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**CAPSULES—14 VITAMINS—11 MINERALS**

LEDERLE LABORATORIES, a Division of  
AMERICAN CYANAMID COMPANY, Pearl River, New York



PROVISIONAL VITAL STATISTICS

Rhode Island Department of Health

January — June, 1959

PROVISIONAL VITAL STATISTICS for the first six months of 1959 are available from vital records filed currently during this period. The data for 1958 are given also to obtain an indication of trends. This report gives the provisional numbers for events that occurred in Rhode Island regardless of the place of residence. The rates are computed on an annual basis.

Births

There were 9,378 live births recorded during the first six months of 1959 representing a decrease of

almost 1 per cent over last year's total for this period. The crude birth rate of 21.1 per 1,000 population was 2.3 per cent below the rate (21.6) for the first six months of 1958.

Marriages

The number of marriages recorded in 1959 (2,630) declined by 1 per cent when compared with this period of 1958 (2,660). The marriage rate per 1,000 population was 5.9, a decrease of 3 per cent over the 1958 rate of 6.1.

TABLE I  
Vital Statistics: Rhode Island, January-June, 1958 and 1959

Item	NUMBER			RATE		
	1959	1958	Per Cent Change	1959	1958	Per Cent Change
Live Births*	9,378	9,462	— 0.9	21.1	21.6	— 2.3
Marriages*	2,630	2,660	— 1.1	5.9	6.1	— 3.3
Deaths*	4,502	4,482	+ 0.4	10.1	10.2	— 1.0
Infant Deaths†	220	197	+11.7	23.5	20.8	+13.0
Neonatal Deaths†	169	151	+11.9	18.0	16.0	+12.5
Fetal Deaths†	161	148	+ 8.8	17.2	15.6	+10.3

\*Rate per 1,000 population  
†Rate per 1,000 live births

Total Deaths

The death rate for the first six months of 1959, 10.1 per 1,000 population, was slightly below the rate of 10.2 for 1958. The number of deaths recorded in 1959 (4,502) was 20 more than for this period of 1958 (4,482). Increases were noted from diseases of the heart, malignant neoplasms, certain diseases of early infancy, tuberculosis, and other diseases. The most substantial decrease was from influenza and pneumonia.

Infant Deaths

The infant mortality rate (23.5 per 1,000 live births) increased 13 per cent over the rate of 20.8 obtained in 1958. In 1959, the number of babies under one year of age who lost their lives was 220,

compared with 197 during this period of 1958. The number and rate for neonatal deaths (under 28 days of age) increased in approximately the same proportions.

Principal Causes of Death

During the first six months of 1959, the ten leading causes of death accounted for 87 per cent of the total deaths. The rank order of the first three causes was the same for 1958 and 1959. Certain diseases of early infancy jumped from tenth place in 1958 to fifth in 1959; influenza and pneumonia dropped from fourth place in 1958 to sixth in 1959. Table II shows the number of deaths with rates per 100,000 population for the ten principal causes of death for 1958 and 1959.

TABLE II  
Deaths and Death Rates per 100,000 population from Ten Principal Causes of Death;  
Rhode Island, January-June, 1958 and 1959

Causes of Death	1959		1958	
	Number	Rate	Number	Rate
1. Diseases of the heart	2,039	459.2	1,898	433.8
2. Malignant neoplasms	790	177.9	770	176.0
3. Vascular lesions	451	101.6	460	105.1
4. Accidents	139	31.3	124	28.3
5. Diseases of early infancy	138	31.1	123	13.0
6. Influenza and pneumonia	106	23.9	174	39.8
7. Diabetes mellitus	87	19.6	112	25.6
8. Other diseases of Circulatory system	62	14.0	60	13.7
9. General Arteriosclerosis	59	13.3	73	16.7
10. Cirrhosis of liver	58	13.1	67	15.3



## new hope for fetal salvage

# DEL

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifstein<sup>1</sup> in a compilation of data supplied by 45 investigators. Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,<sup>2</sup> in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy

64% of 42 pregnancies were salvaged by progesterone

83% of 73 pregnancies were salvaged by Delalutin

Eichner,<sup>3</sup> found that in Delalutin-treated women, fetal salvage of infants below term

weight (1000 to 2000 gm.) was significantly improved. 108 (76%) of 142 babies of birth weight survived without mothers receiving progestational therapy, while 16 (10%) of 16 babies of this birth weight survived mothers receiving Delalutin therapy. A comparison study was made of a group of repeated aborters treated with Delalutin and a group with a similar history treated with bed rest and sedation.<sup>4</sup> Fetal salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active", well-tolerated and long acting.

According to Tyler and Olson,<sup>5</sup> "The qualities of prolonged action and relative freedom from local reactions make [Delalutin] a generally more desirable therapeutic agent for intramuscular than progesterone . . ."

### DELALUTIN BABIES WHOSE MOTHERS WERE HABITUAL ABORTERS



Mary Ann Cribben  
Garden City, N. Y.



Amy Sue Greenman  
Lincolnwood, Ill.



William Peller  
Skokie, Ill.



Randy Sinis  
Denver, Colo.



Richard Miller  
Denver, Colo.



Scott Knudsen  
Norwich, Vt.

References: 1. Reifstein, E. C., Jr.: *Annals N. Y. Acad. Sci.* 71:762 (July 30) 1958. 2. Boschann, H.-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. & Gynec.* 76:279, 1958. 5. Tyler, E. T., and Olson, H. J.: *J. A.M.A.* 169:1813, 1959.

# DELALUTIN<sup>®</sup>

*improved  
progestational  
therapy*

SQUIBB HYDROPROGESTERONE CAPROATE

*DELALUTIN offers these advantages over other progestational agents:*

- long-acting sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requiring injection of less vehicle
- unusually well-tolerated, even in large doses
- fewer injections required
- low viscosity makes administration easier

DELALUTIN is also potent and safe therapy for: threatened abortion; postpartum after-  
ings; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated  
th genital malignancy; infertility with inadequate corpus luteum function; production of  
retory endometrium and desquamation during estrogen therapy; premenstrual tension;  
smenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

## *Administration and dosage:*

Because of its low viscosity, Delalutin may be admin-  
istered with a small gauge needle (deep intragluteal  
injection). Complete information on administration  
and dosage is supplied in the package insert.

## *Supply:*

Delalutin is available in vials of 2 and 10 cc.,  
each containing 125 mg. of hydroxyproges-  
terone caproate in sesame oil, and benzyl  
benzoate.

*of these healthy, normal babies was born by a mother with a documented previous history  
of habitual abortion, who was treated during her most recent pregnancy with DELALUTIN.*



Rutkowski  
selle, Ill.



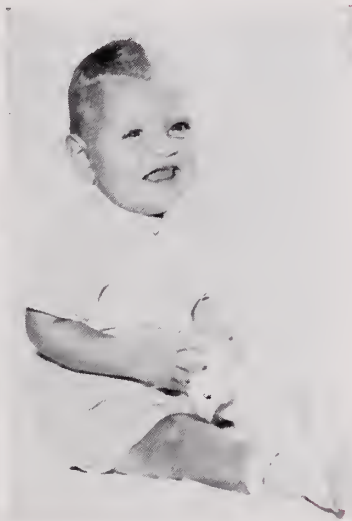
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CLINICAL BRIEFS  
FOR MODERN PRACTICE



## *How can the problem of "postcholecystectomy syndrome" be reduced?*

A "routine" operative cholangiogram is now recommended in addition to thorough surgical exploration, reducing the number of cholecystectomized patients later presenting the same symptoms as before the operation.

Source: Vazquez, S. G.: J. Internat. Coll. Surgeons 28:394, 1957.

*for pre- and postoperative  
management of biliary  
tract disorders...*

**DECHOLIN<sup>®</sup>** "therapeutic bile"

Hydrocholeresis with DECHOLIN combats bile stasis by flushing the biliary tract with dilute, natural bile...

- corrects excessive bile concentration
- helps to thin gallbladder contents
- benefits patients with chronic cholecystitis, noncalculous cholangitis, and biliary dyskinesia

*in functional G.I. distress...*

**DECHOLIN<sup>®</sup>**  
with **BELLADONNA**

- reliable spasmolysis
- improved liver function

available: DECHOLIN Tablets: (dehydrocholic acid, AMES) 3¾ gr. (250 mg.). Bottles of 100, 500 and 1,000; drums of 5,000.

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no "count-down" is needed  
with **SUS-PHRINE**

(Aqueous subcutaneous epinephrine suspension 1:200)

**Sus-Phrine acts quickly and its action is sustained**

for

acute bronchial asthma  
anaphylactic shock  
drug and allergic reactions  
urticaria  
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*proven by long clinical use.*

"...we have had considerable experience with, and have been favorably impressed by, the action of an aqueous suspension of epinephrine, Sus-Phrine 1:200 (Brewer). This material has a decided advantage over epinephrine suspended in oil."

Levin, Samuel J.: Management of the Acute Asthmatic Attack in Childhood. *Ped. Clin. of N. A.* 1:975, (November) 1954.

"Its action is about as prompt as the solution, manifested in 1 to 5 minutes, and as prolonged as the oil suspension, lasting 8 to 12 hours."

Naterman, H. L.: Epinephrine Base Suspended in Water with Thioglycollate. *J. Allergy* 24:60, (Jan.-Feb.) 1953.

"Greatest individual acceptance of the new injection has been by children. The dosage is small enough to be handled easily (0.30 to 0.40 cc. in adults; 0.15 to 0.20 cc. in children)."

Unger, A. H., and Unger, L.: Prolonged Epinephrine Action. A Report on Use of an Epinephrine Suspension. *Ann. Allergy* 10:128, (Mar.-Apr.) 1952.

"Sus-Phrine is a valuable therapeutic adjunct in the treatment of bronchial asthma, urticaria and angioneurotic edema..."

Jenkins, C. M.: A Clinical Study of "Sus-Phrine", an Aqueous Epinephrine Suspension for Sustained Action. *J. Nat. M. A.* 45:120. (Mar.) 1953.

Chronic asthmatics can be quickly taught to self administer Sus-Phrine subcutaneously in acute attacks, eliminating need for emergency calls.

supplied

| In 0.5 cc. ampuls, packages of 12. Also in 5 cc. multidose vials.

*Brewer*  
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One of the most important benefits of Industrial's *Convertible* Living Trust is its unique flexibility. Thanks to this flexibility, the type of investment service you receive varies in accordance with your requirements.

Under normal circumstances, the *Convertible* Living Trust functions primarily as your investment "bookkeeper," handling the time-consuming chore of detailed record keeping and other paperwork for you. You continue to exercise full control of your own investments.

However, if at any time you become temporarily or permanently unable to

actively manage your investments, the automatic "convertibility" of this Trust permits Industrial National's skilled trust officers to assume management of your estate immediately — for as long a period as your circumstances require.

### ***Convertible* Living Trust advantages:**

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- Helps avert financial losses in any "change-over" period
- Assures maximum pro-

tection of your investments if your beneficiaries lack investment knowledge or experience

- Takes care of burdensome paperwork for you, now and in the future

Get full information today about our *Convertible* Living Trust. There's no obligation. Write to our Trust Department, Box 1466, Providence, or call Jackson 1-9700, extension 534.

TRUST DEPARTMENT

## **Industrial**

**NATIONAL BANK**

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Fiber of skeletal muscle in spasm

Fiber of skeletal muscle relaxed (photomicrographs)

CLINICALLY  
PROVEN  
—prolonged  
relaxation  
of acute  
skeletal  
muscle  
spasm



# Robaxin<sup>®</sup>

Methocarbamol Robins

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TABLETS

## Summary of six published clinical studies:

**ROBAXIN BENEFICIAL IN 92.4% OF  
SKELETAL MUSCLE SPASM CASES**

	NO. PATIENTS		RESPONSE		
		"marked"	moderate	slight	none
Carpenter <sup>1</sup>	33	26	6	1	—
		"pronounced"			
Forsyth <sup>2</sup>	58	37	20	—	1
		"good"			
Lewis <sup>3</sup>	38	25	6	—	7
		"excellent"			
O'Doherty & Shields <sup>4</sup>	17	14	2	1	0
		"significant"			
Park <sup>5</sup>	30	27	—	2	1
		"gratifying"			
Plumb <sup>6</sup>	60	55	—	—	5
TOTALS	236	184 (78.0%)	34 (14.4%)	4	14

- Highly potent—and long acting.<sup>1,2,3</sup>
- Relatively free of adverse side effects.<sup>1,2,3,5,6</sup>
- In ordinary dosage, does not reduce muscle strength or reflex activity.<sup>1</sup>

REFERENCES: 1. Carpenter, E. B.: Southern M. J. 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Lewis, W. B.: California Med. 90:26, 1959. 4. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 5. Park, H. W.: J.A.M.A. 167:168, 1958. 6. Plumb, C. S.: Journal-Lancet 78:531, 1958.

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hemorrhoidal

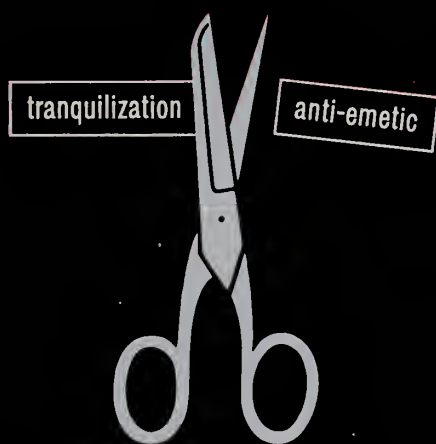
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*with cod liver oil*

*Samples* and literature available from

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# now potent tranquilizer therapy is safer than ever



*Virtual freedom of Mellaril from major toxic effects is due to greater specificity of tranquilizing action—divorced from such "diffuse" effects as anti-emetic action.*

MELLARIL is virtually free  
of such toxic effects as

- jaundice
- Parkinsonism
- blood dyscrasia

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines. . . . This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."<sup>1</sup>



# Mellaril®

THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels

## remarkable lack of side effects

In more than 3,000 carefully-followed patients, Mellaril has been almost completely free of such major side effects as **jaundice, extrapyramidal symptoms, Parkinsonism, blood dyscrasia, dermatitis**—even when given in quantities far in excess of the usual dosage.

### "POVERTY" OF SIDE EFFECTS

"The most striking aspect of thioridazine [Mellaril] therapy is the poverty of side effects.... In its lack of side effects and low toxicity, it is superior to all other tranquilizing drugs tested. For this reason also it is well tolerated by patients, particularly those who are not hospitalized and who frequently discontinue their medication because of dizziness, sleepiness, increased tension or parkinsonism with other drugs."<sup>2</sup>

### NEGLIGIBLE SIDE EFFECTS

"Side effects were negligible at all dosage levels: no incidence of parkinsonism or other extrapyramidal symptoms. Minimal sedation, on the whole lower than with other tranquilizing agents. No alteration in liver function, urine or blood. No photosensitivity. Patient acceptability was exceptional: lack of drowsiness, lethargy or 'washed out' feeling, permitted patients to carry on normal everyday activities. Orthostatic hypotension was absent. The initial 'keyed up' tense feeling common to other drugs of this type was absent.... Patients forced to interrupt treatment with other phenothiazine derivatives because of parkinsonism or other extrapyramidal symptoms were able to continue therapy with thioridazine without appearance of parkinsonism."<sup>3</sup>

### SINGULARLY FREE OF SIDE EFFECTS

"The extrapyramidal syndrome was not encountered in

any of its forms. Dizziness and sleepiness responded to a reduction in dosage. Other side effects did not occur.... It is singularly free from the side effects ordinarily seen with these [phenothiazine] compounds."<sup>4</sup>

### ABSENCE OF SIGNIFICANT SIDE EFFECTS

"None of the following toxic effects, so common after administration of the phenothiazines, was present during the period of Thioridazine administration: Parkinsonism or Parkinson-like symptoms, photosensitivity, orthostatic hypotension, bone-marrow depression."<sup>1</sup>

### MINIMAL SIDE EFFECTS

"Side effects such as extrapyramidal activity, jaundice and photosensitivity have not been observed in patients treated with Thioridazine [Mellaril]. Extrapyramidal side effects produced by other phenothiazines have disappeared promptly with no deterioration in the behavioral response when these patients have been shifted to Thioridazine."<sup>5</sup>

### NO JAUNDICE

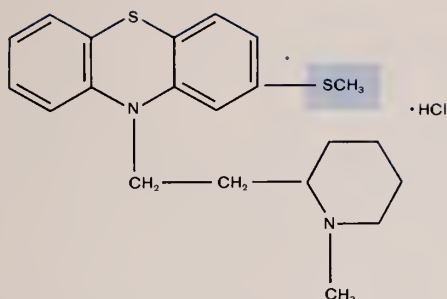
"No allergic reactions were observed such as skin eruptions, jaundice or agranulocytosis. Central nervous system toxicity, as manifested by extrapyramidal effects, seizures, and excitement did not occur despite the use of high doses (up to 2000 mg.) of the drug."<sup>6</sup>



The graphic features the word "Mellaril" in a large, white, serif font, with a registered trademark symbol (®) to its upper right. Below it, in a smaller, white, sans-serif font, is "THIORIDAZINE HCl". At the bottom, in an even smaller, white, sans-serif font, is the phrase "specific, effective tranquilizer • safer at all dosage levels". To the left of the text is a stylized, orange, wavy line. To the right is a blue, wavy line. A pair of white scissors is positioned as if cutting the blue line. Above the scissors are two small, white, rectangular labels with black text: "tranquilization" and "anti-emetic".

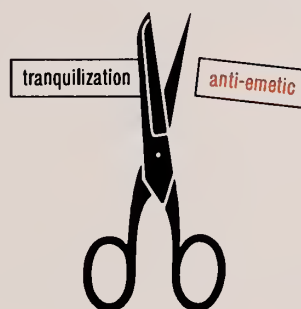
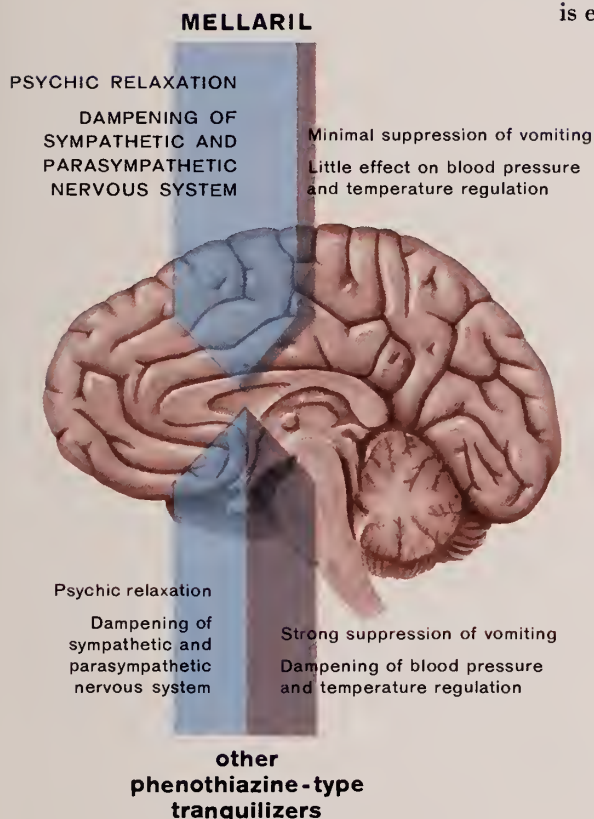


a new advance in tranquilization:  
greater specificity of tranquilizing action plus fewer side effects



*Of 109 phenothiazines synthesized by Sandoz, Mellaril was selected as the most promising on the basis of extensive evaluation. The presence of a thiomethyl radical (S-CH<sub>3</sub>) in the position conventionally occupied by a halogen in other phenothiazines is unique and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:*

- 1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.

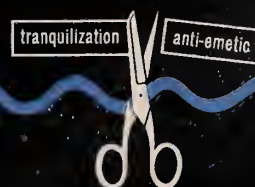


- 2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.
- 3 A notable absence of extrapyramidal stimulation.
- 4 Lack of impairment of patient's normal drive and energy, while achieving psychomotor control in mental and emotional disorders.
- 5 Virtual freedom from toxic effects — jaundice, photosensitivity, skin eruptions, disturbed body temperature regulation, blood forming disorders have been absent in reports currently available.

These properties add up to a greater margin of safety in general office practice, in ambulatory psychiatric out-patient clinics, and in hospitalized patients.

**Mellaril®**  
THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels



## excellent clinical response

In office practice and in hospitalized patients, Mellaril has proved highly useful for a wide variety of major and minor emotional disorders (such as anxiety, tension, apprehension, alcoholism, agitated psychoneurosis, agitated psychotic states, etc.).

**EXTREMELY SATISFACTORY** "... produced extremely satisfactory results in the broad therapeutic range represented in this series."<sup>3</sup>

**POTENT AGENT** "... appears to be a potent agent in the symptomatic management of a variety of psychiatric states."<sup>4</sup>

**MAJOR ADDITION TO THERAPEUTICS** "This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."<sup>1</sup>

**AN ACTIVE AGENT** "Thioridazine is an active therapeutic agent. . . . It is effective in a variety of psychiatric disorders, including schizophrenic reactions. . . . The drug is particularly advantageous for a group of schizophrenic patients who are sometimes made worse by other phenothiazine derivatives or Rauwolfia alkaloids. It should also be suitable for treating patients with psychoneuroses and chronic brain syndrome."<sup>6</sup>

**EVEN IN VERY SEVERE CASES** "Of the 152 patients treated 25 have been released and they have not suffered a relapse. This proportion is significant if we stop to consider that we are dealing only with acute cases which had been considered hopeless and obviously destined to finish their days in an asylum."<sup>7</sup>

**EXCELLENT THERAPEUTIC RESPONSE** "Patients with emotional tensions resulting from the stress and strain of life . . . were treated with Mellaril at the dosage level of 10 mg. three times daily. In 94 such patients, 83 obtained an excellent therapeutic response."<sup>8</sup>



# Mellaril<sup>®</sup>

THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels

tranquilization

anti-emetic



“... extremely satisfactory results ...”  
in a clinical spectrum ranging from  
minor nervous disorders to  
severe psychotic disturbances<sup>3</sup>

#### RESULTS WITH MELLARIL IN 194 PATIENTS<sup>3</sup>

##### ACUTE PSYCHOTICS

83% satisfactory effect

Some cases had complete re-  
mission of symptoms. Most  
were able to return home to  
useful occupations.

##### CHRONIC PSYCHOTICS

68% satisfactory effect

Relief of symptoms in cases  
permitted easier management  
and a return to a more or less  
useful life.

##### NEUROTICS

57% satisfactory effect

Some cases, complete relief of  
symptoms. Other cases, partial  
relief of symptoms.

#### RESULTS WITH MELLARIL IN PATIENTS PREVIOUSLY TREATED WITH OTHER TRANQUILIZERS<sup>3</sup>

DIAGNOSTIC CATEGORY	IMPROVED %	VERY SATISFACTORY %	SATISFACTORY %	UNSATISFACTORY %
<b>SCHIZOPHRENIA</b>				
Acute	89	61	28	11
Chronic paranoid	84.2	31.6	52.6	15.8
Chronic, other	73.9	21.7	52.2	26.1
Residual	57.1	9.5	47.6	42.9
<b>CHRONIC BRAIN SYNDROME</b>	66.6	33.3	33.3	33.3
<b>CHRONIC PSYCHONEUROSIS</b>	62.5	12.5	50	37.5
<b>CHRONIC PSYCHOSOMATIC DISORDERS</b>	75	25	50	25

**Mellaril<sup>®</sup>**  
THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels

tranquillization

anti-emetic





# a guide to administration and dosage

Dosage ranges from 10 mg. three or four times a day in milder situations to 25 mg. three or four times a day for more disturbed patients. In ambulatory psychiatric out-patients, dosages of 50 to 100 mg. three or four times a day have been found adequate. For severely dis-

turbed hospitalized psychotics, dosages of 200 to 300 mg. three times a day may be administered.

Dosage must be individualized according to the condition and degree of response. In all cases, the smallest effective dosage should be determined for each patient.

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
ADULTS		
Mental and Emotional Disturbances:		
MILD—where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg.
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Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959. 2. Kinross-Wright, V. J.: Lecture, Clinical Meeting, American Medical Association, Minneapolis, Dec. 4, 1958. 3. Kinross-Wright, V. J.: Scientific Exhibit, Clinical Meeting, American Medical Association, Minneapolis, Dec. 2-5, 1958. 4. Cohen, S.: TP-21, a new phenothiazine, *Am. J. Psychiat.* 115:358, Oct. 1958. 5. Glueck, B.: Scientific Exhibit, American Psychiatric Association, Philadelphia, April 27-May 1, 1959. 6. Hollister, L. E., and Macdonald, B. F.: Presented at California Medical Association; Section on Psychiatry, San Francisco, Feb. 25, 1959. 7. Remy, M.: *Schweiz. med. Wchnschr.* 88:1221, Nov. 29, 1958. 8. Freed, S. C., in discussion on Thioridazine (Mellaril) Psychiatric Patients, Hollister, L. E., and Macdonald, B. F., presented at California Medical Association; Section on Psychiatry, San Francisco, Feb. 25, 1959

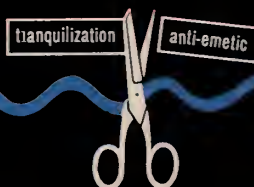
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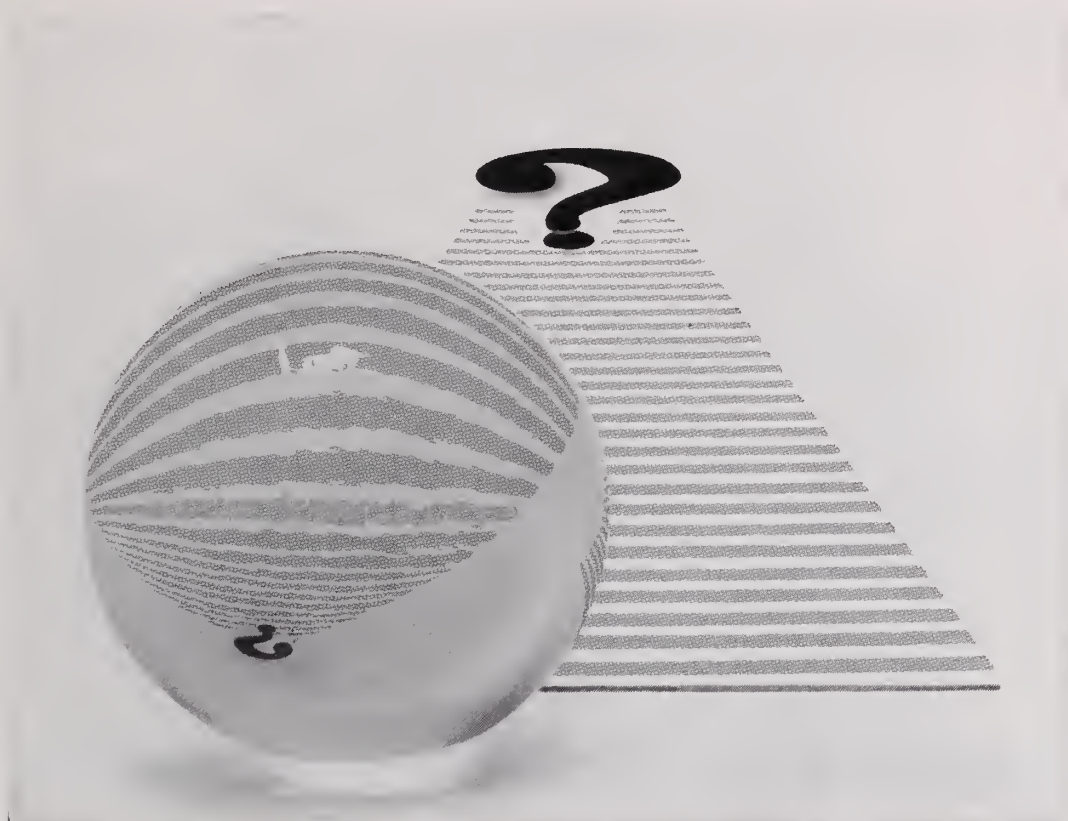
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References: 1. Dowling, H. F.: Postgrad. Med. 23:564 (June) 1958. 2. Gimble, A. I.; Shea, J. G., and Katz, S.: Antibiotics Annual 1955-1956, New York, Medical Encyclopedia Inc., 1956, p. 676. 3. Long, P. H., in Kneeland, Y., Jr., and Wortis, S. B.: Bull. New York Acad. Med. 33:552 (Aug.) 1957. 4. Rein, C. R.; Lewis, L. A., and Dick, L. A.: Antibiotic Med. & Clin. Ther. 4:771 (Dec.) 1957. 5. Stone, M. L., and Mersheimer, W. L.: Antibiotics Annual 1955-1956, New York, Medical Encyclopedia Inc., 1956, p. 862. 6. Campbell, E. A.; Prigot, A., and Dorsey, G. M.: Antibiotic Med. & Clin. Ther. 4:817 (Dec.) 1957. 7. Chamberlain, C.; Burros, H. M., and Borromeo, V.: Antibiotic Med. & Clin. Ther. 5:521 (Aug.) 1958. 8. From, P., and Allil, J. H.: Antibiotic Med. & Clin. Ther. 5:639 (Nov.) 1958.

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## *The Eighth Annual Arthur Hiler Ruggles Oration—*

### NEW KNOWLEDGE FOR BETTER MENTAL HEALTH\*

JACK R. EWALT, M.D.

---

*The Author, Jack R. Ewalt, M.D., Professor of Psychiatry, Harvard University, Faculty of Medicine; Director, Joint Commission on Mental Illness and Health.*

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WHEN ASKED to design a survey of the mental health resources of the nation and to make recommendations for future plans, the Joint Commission on Mental Illness and Health and its staff decided to orient the study around individuals rather than around various professional groups and services. We wished to find out what people do when they become unhappy, worried, mentally ill, or otherwise troubled. Lacking facilities to do a complete medical and social work-up on each person in the country, or a sample of them, we decided that it would be possible to interview a sample of people and by this means find where they sought help when troubled or distressed. We believed that people seeking aid for problems would go to some type of organized helping agency, either the medical profession, a hospital, or a clinic, or to one of the nonmedical helping organizations often called social agencies. We also believed that a substantial number would turn to their clergymen for help.

A similar line of reasoning led us to believe that people seek to improve their general well-being by use of various social institutions and agencies, some of those used by people ill, but also others such as recreational agencies and the educational facilities of the nation.

Obviously, we needed to determine the available manpower in terms of persons to supply service in the health promotion or treatment agencies. And the staff believed we should make some determination of the advances being made in the research field and to study factors that might interfere with development of research programs. And finally we

thought we should make some effort to establish methods of determining the cost of mental illness in financial terms.

Three of our eleven projected monographs have already been published, and these will not be extensively reviewed here. Rather, it is our desire to touch on some parts of the results that are still in manuscript form. We will select some areas that we think are of interest.

We asked the Survey Research Center at the University of Michigan to conduct a sample survey to determine what makes people in the nation worried or unhappy and the agencies or persons rendering aid to them in their distress. The Survey Research Center staff headed by Angus Campbell and Gerald Gurin, working with our staff, developed a schedule of questions to ask the people included in the sample. The pilot, or testing, of the questionnaires was done carefully and extensively, and the Survey staff of interviewers were also especially coached and trained in handling this particular study. The Joint Commission is pleased with the way the study was handled by the Survey Research Center.

Obviously, the material obtained is only that portion of the mental attitudes and feelings of the population that is measurable in an interview, and the material represents a sample of the American population, including their satisfactions and dissatisfactions, things about which they are concerned, as well as the resources and strength they bring to bear on these problems. This study reveals that people of different socio-economic groups and of different education differ in the satisfactions they achieve and the problems which they experience in life. The study presents a great deal of material of a detailed sort that will be useful in planning mental health services for various population groups. The study revealed that people who seek help for personal problems tend to have a psychological orientation to life; that is, they are introspective and self-questioning. Those persons lacking this psychological orientation when faced with a mental health problem did not express readiness for referral to a professional source of help. People with a psychological orientation tended to have

*continued on next page*

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\*Presented at the Annual meeting of the Rhode Island Association for Mental Health, at the Providence Public Library Auditorium, Providence, Rhode Island, May 7, 1959.

Based on a three-year study authorized and financed by Congress for a survey of the mental health resources of the nation to be made by the Joint Commission on Mental Illness and Health.



psychological rather than physical symptoms as a response to their stress. The expression of psychological orientations to problems was present in highest percentage in women, younger people and the better educated. These same groups were the ones most ready to refer themselves to professional sources for help.

Of tactical significance to persons planning service for the mentally ill is the information about the sources of happiness and of unhappiness and of worry. Leaving aside for a moment the ways in which people expressed happiness or unhappiness, one can say that the major national issues, the international situation, the threat of atomic fallout, the housing shortage, high taxes, inflation and crowded highways, that are reputedly causing our society great tension and stress, appeared as an important source of worry in a very small number of people. People seem to derive their satisfactions from rather mundane things, their income, their families, their children and their community activities. Correspondingly, the things about which they are worried and concerned are their health, their families, their children, money, the state of their jobs and the everyday personal tribulations with which people are faced.

The information that people worry over rather personal matters is in a way encouraging. The national trend toward improving community services for persons under personal or economical stress by improving general health services, job security, economic security for people out of work, plus our declining death rate, especially in children, is directed toward the major reasons given as causes of unhappiness and worry by the sample population.

Another important fact emerging from this study is that people who define their problems in psychological terms make up approximately one fifth of the population. At least one fifth of the population answered the question, "Have you ever felt you were going to have a nervous breakdown?" in the affirmative. Four per cent of the total sample felt the causes of their problems were external to themselves, that is, difficulty within their family, problems on the job, or other interpersonal difficulties. About 10 per cent of the total population felt that the problem was within themselves, and they would have benefited from professional help. About 14 per cent of the people interviewed had sought professional help. In seeking help people tend to go to their clergymen, to their family doctor and to the psychiatrist in that order of frequency. There is some further definition, however, in that those who tended to define their problems as psychological seek psychiatric aid in larger proportions than those seeking help for more external problems.

While no study of this extent has ever been done, smaller studies and studies done for other purposes

tend to show that people are reluctant to consult with psychiatrists. While we have no evidence from this study that this is not so, the actual number who state that they have sought psychiatric aid was surprisingly large when one considers the problem of the small number of psychiatrists and the percentage of them concentrated in certain large cities. When one considers that there are about 350,000 clergymen and 150,000 physicians available for people to consult, both fairly well distributed throughout the country in cities and rural areas, and when one considers that there are at most ten to fifteen thousand psychiatrists available, it is amazing that more than 2,000,000 people in this country have consulted psychiatrists because they thought they were going to have a nervous breakdown. On the basis of availability in numbers, the rate of consulting a clergyman should be 20 times, and the general physician at least 10 times the rate of patient consulting with psychiatrists. In fact, the ratio runs approximately 4 to 1 and  $2\frac{1}{2}$  to 1. This survey also found that the problems presented by the patients vary, or perhaps influence the agency to which they turn. The socio-economic status of the individual seems to play an important part in determining whether or not he defines his problems in psychological terms. But within groups persons with marital problems tend to consult a clergyman, a general physician, or a marriage counselor. On the other hand, people with problems with their children, or with personal adjustment problems which they interpret as psychological, more often consult with a psychiatrist. Most people choose of their own volition the kind of help they seek, but about 8 per cent of those seeking help were referred by their physicians, and families and friends referred another 8 per cent of those seeking help. About one per cent sought help because of something they read or heard in some of the mass media, and about one per cent were referred by the clergy.

This phase of the study has two important implications:

- (1) That current efforts to aid the clergy and the family physicians become competent to offer counseling to the mentally disturbed serve an important function, since we know that people are already consulting these persons in large numbers.

- (2) We know that people are ready to consult psychiatrists and apparently do so in relatively large numbers in spite of poor distribution.

As the manpower report shows, our expectations of having any large increase in the number of psychiatrists available in the immediate future are poor indeed; therefore, every effort should be made to expedite the production of additional ones and

perhaps even more importantly, to make certain that we make the best possible use of the ones that we now have.

The size of the mental health problem will vary by definition of mental illness and disturbed behavior to be classed as mental illness. We can estimate the patients who actually seek psychiatric care. On an average day there are approximately 640,000 patients hospitalized with a mental disorder, or if one includes the mentally retarded, more than 700,000 persons. These people are cared for in the 1,250 hospitals who state that they accept mentally ill persons for diagnosis and treatment. About 85 per cent of the patients are found in large state hospitals, most of which have 500 or more beds. About 430,000 different patients are admitted to the nonfederal psychiatric facilities each year, 270,000 of these to the specialized mental hospitals, and the remaining 160,000 to the psychiatric units in general hospitals. The admissions, plus those already there at the first of any year, bring the total number of persons hospitalized in a year to 1,070,000. Approximately 30 per cent of the patients admitted in any year have been hospitalized at least once before for mental illness. One third of the admissions to all public and private mental hospitals are 55 years of age or older, and many state hospitals of the larger type report that a third or more of their patients are 65 or older on admission. The general use of psychiatric resources can be summarized in terms of the total hospital facilities. There are 6,818 registered hospitals in the country, of which 7 per cent are psychiatric. These 6,818 hospitals have 1,558,691 beds, of which 45 per cent are psychiatric. The average census of all the hospitals on any day is 1,300,000, and of these patients 51 per cent are psychiatric. On the other hand, of the 23,000,000 admissions in a year, only 2 per cent are psychiatric, and of the 1,400,000 personnel in all categories hired by the 6,800 hospitals only 17 per cent are employed in psychiatric hospitals.

Thus, as we well know, our mental hospitals are large, overcrowded, understaffed and have many long-term patients.

In addition, we estimate that the mental health clinics of all types treat at least 380,000 patients in a year, and that psychiatrists treat somewhere around 400,000 (give or take 30,000) in their offices. It is estimated that the number of psychiatric patients attended by internists and general practitioners varies from 10 to 50 per cent. We have no way of estimating the exact number, nor do we know how many of these patients find their way into the above-mentioned psychiatric offices, psychiatric clinics, or mental hospitals.

There have been many attempts to count the mentally ill in the community. The attempts were

made in various places at various times, but for different purposes, by different staffs, all of whom seem competent. Apparently, the more intensive the survey of the community, the larger number of patients discovered. The prevalence figures in these surveys give a rate in the United States varying from 44 per thousand to the largest, 213 per thousand. The Michigan material, which is in no sense a prevalence survey, found more than two million persons who say they sought psychiatric help at some time, and these figures do not include patients in hospitals or persons in armed forces. On the basis of the epidemiologic studies done, one may estimate that about 10 per cent of our population have nervous or mental illness of sufficient severity to warrant treatment of an appropriate type. This would mean 17,500,000 now in the nation. Our estimates show that 1,800,000 are treated in medical agencies in a year, or approximately 10 per cent of the potential crop. In terms of adequacy of these treatment resources, we have found no community which believed it had enough hospital beds for the mentally ill and enough clinics to take care of the mental health problems known to exist, or enough psychiatrists to take care of the people wishing psychiatric care.

George Albee made an exhaustive study of the manpower problem of psychiatrists, psychologists, social workers and nurses. No detailed studies were made of the other professions working in the mental health field, as we believed these principal ones would serve as examples of the total situation. Doctor Albee's results can be summarized in one statement. We do not have enough trained people and not enough persons are entering universities with an interest in this field so that we can expect adequate numbers in the foreseeable future. This can only mean that we will ultimately fail in our attempts to supply needed services using techniques based on our present knowledge of the cause and treatment of mental illness. One can make the conclusion that we should at this time withdraw some money and some manpower from the support of treatment services, with full realization that this means further neglect of already poorly cared for patients, and use the competent manpower and money for research on cause and more effective treatment of the mentally ill. Further research is needed on the effective use of existing manpower through research in administration and research in methods of recruitment of additional numbers of young people into colleges and universities and then into the professional fields.

Mental hospitals in the United States and in several European countries are developing new therapeutic methods for the care of the mentally ill. Some states have introduced new programs for the management of patients in the community. Others

*continued on next page*



have developed active programs in the mental hospital. Morris Schwartz and his co-workers have focused their attention primarily on the new trends in the field, using conventional treatment systems as a background against which to analyze these new trends. They have observed programs associated with these trends in a number of selected institutions; they have talked with many experts in the field of mental patient care, and they reviewed the current literature on hospital and community patterns of care. With this and their own previous experience in the field as a context, they formulate in their report an analysis of the trends in the field, and the problems various programs are trying to solve, their impressions of the major issues in the field of mental patient care and their suggestions and recommendations as to what might be done to improve care for mental patients in the United States.

As an illustration of the kinds of trends Schwartz and his colleagues were concerned with, we shall discuss the trend to give to patients who become mentally disturbed immediate treatment in the community.

The hiatus between the time a person becomes mentally ill and the time he receives professional treatment has, for a long time, been a concern of practitioners. The long waiting lists in mental health clinics and the scarcity of private psychiatric time have led to new programs. Some of these programs have concentrated on providing emergency psychiatric care while the patient stays in the community. They have attempted, either by a psychiatric team visiting the patient's home or by having a psychiatrist on call at all times in the psychiatric section of a general hospital, to narrow the time interval between the acute eruption of mental illness and the giving of professional help. The details of how these programs can be most effectively conducted are still in the process of development. However, the problems that these programs are grappling with are quite clear; they are primarily how to reach the patient when he most needs help; how to keep him out of the hospital while he is getting help; and how to maximize the effectiveness of scarce professional time by initiating appropriate intervention at the most appropriate time. It is our impression that these programs of emergency care are "paying off" and our recommendation is that they be continued and extended, while at the same time their efficacy and the conditions of their success and failure are investigated.

Morris Schwartz and his group have done a similar analysis of a number of other programs dealing with the community care of mental patients. Their report will discuss attempts to extend the out-patient treatment system into the community, into the courts, prisons, industry, the general hos-

pital, the school and a variety of social agencies. It will also discuss various attempts to broaden the conception of treatment, where, for example, families as a group are being treated, or consultation is being given to public health nurses to facilitate their handling of mental patients.

A large variety of new programs have been initiated in mental hospitals throughout the country. Some of these programs have emerged in the course of practitioners' attempts to develop therapeutic milieu in their hospitals. Schwartz and his co-workers analyzed this trend to develop therapeutic milieu and found many imaginative and original programs are being tested in different hospitals. Thus, hospitals have changed their atmosphere by giving greater freedom to patients; they have changed the role of personnel and patients, and in the case of the patients, have afforded them greater opportunities to make decisions about and take responsibility for their own lives; they have instituted many procedures oriented toward bringing lower echelon personnel into the decision-making process; they have freed communication between the different levels of staff; they have developed the conception that many types of personnel might be of therapeutic significance to the patient, and they have introduced novel ways in which the therapeutic potential of personnel is used. The issues practitioners have concerned themselves with in developing therapeutic milieu are related to the physical and social organization of the hospital. They are experimenting particularly with the redefinition of roles and role-relations in the hospital in order to maximize its therapeutic impact.

These programs of developing therapeutic milieu appear to us to hold much promise for changing the mental hospital so that it makes a greater contribution to patient improvement. We suggest that many different kinds of attempts be made to develop therapeutic milieu; and that the details and operations of these attempts be carefully investigated.

The Schwartz group have studied in a similar fashion attempts to break down the barriers between the hospital and the community. Here such programs as the open hospital and the psychiatric section of the general hospital are discussed. In addition, they have described programs where the individualization of care for patients has been the focus of concern. They describe and analyze a variety of programs in which, through different procedures, the particular needs of patients are assessed, planned for and met.

The final set of trends Schwartz and his co-workers analyze is in the area of aftercare. A large number of facilities have been developed, and new programs are being introduced to help patients accommodate to the outside world. Some of these facilities and programs are halfway houses, foster



family care, sheltered workshops, vocational counseling, rehabilitation centers, social clubs, and the use of public health nurses to follow up patients. As an illustration of the trends in this field, they discuss the ways in which practitioners are providing continuity of care for patients discharged from the mental hospital. Some programs concentrate on providing continuity of care through the same person, trying to ensure that the staff member who saw the patient in the hospital will also see him after he has been released. Other programs try to provide whatever kind of help the patient is thought to need, be it help in the work area, in the family area, or in the recreational area. In each program the central issue is to continue care for the patient in a way that fits him. Discovering the specifics of a particular program that will suit different types of patients are areas that require continuing investigation.

Two other trends in aftercare are similarly discussed: the grading of stress for ex-mental patients, and the tailoring of treatment for them. Programs of grading stress concern themselves with developing optimum "pressures" on patients to facilitate their performance. Programs of tailoring treatment for ex-patients are oriented toward finding the particular rehabilitation activity most needed by a patient. Each of these trends holds out promise for reducing the numbers of patients returning to the mental hospital and for enabling released patients to assume a more effective role in society. We recommend their expansion and continuing research to increase their effectiveness.

As a result of new treatments, chemical, psychological and social, changed attitudes of staff and the surrounding community and probably other factors not detected, there has been a substantial reduction in the number of resident patients in the hospitals of the country. The number of beds actually emptied by discharge of patients, plus the former annual increase in the population of mental hospitals, mean an over-all saving of several thousands of hospital beds.

Community mental health services have expanded in the past several years. A few states have laws which make it possible for the state and community to collaborate in support of local mental services. Pilot programs made possible through grants in aid from the National Institute of Mental Health played a very large role in demonstrating the effectiveness of these clinics and in subsidizing the states to start them. However, there seem to be other factors at work in the population not easily described. The demand for psychiatric and other mental health services in agencies previously not thought to require such professional help is growing apace. For example, psychological testing and assessments in industry are in great demand. Courts,

prisons, juvenile agencies, social agencies, school systems and industries are requesting psychiatric services. Agencies once content with diagnostic services from psychiatrists and psychologists now demand treatment for their clientele. Furthermore, by treatment they often mean one-to-one, intensive psychotherapy, psychoanalysis, or at a very minimum intensive, psychoanalytically oriented group therapy. One state has more than 60 psychiatrists and psychologists giving intensive therapy to offenders at the court or prison level — this in addition to long-time established traditional diagnostic services. Whatever the causes, these demands for mental health clinics and allied services are growing more rapidly than the manpower pool for staffing them.

The inauguration of new services is not always carefully planned. Some new services have been started without co-ordination and full use of existing services in the community. The desire to create new services often stems from a wish to do something about something, and the belief that the creation of a mental health clinic or counseling and guidance service will somehow care for the social ills and unhappiness of a community. Fortunately, there is a growing tendency for communities to make a survey of their needs and resources before starting a new service. The importance of careful planning to utilize existing services to their maximum cannot be over-emphasized. The demands for new services are growing more rapidly than the complement of personnel to operate them, and as a nation we are not gaining on our professional manpower shortage, but rather we continue to lose ground. There is a trend to develop mental health services in the community that are health promoting as well as therapeutic, and we believe this is a productive trend.

Many communities lack the basic resources and agencies necessary for mental health promotion and the treatment of mentally ill persons. Reginald Robinson and his group made a statistical study of the 3,103 counties in the nation (exclusive of Alaska, Hawaii and Puerto Rico). Two thousand counties have no psychiatrists. Two thousand have no community family service societies, and 1,500 have no public child welfare services.

A site survey in a representative sample of the counties shows that where community services are lacking, some people are not able to obtain needed help. Most counties studied recognize the need for development of community services, and there is an encouraging trend to use welfare workers, county health nurses and other agencies to help augment the services made available through mental health clinics and hospitals. In the more sparsely located areas the clergy and the family physicians may assume the major responsibility for mental

*concluded on next page*

health counseling, and the physicians treat the more seriously ill until they may be referred to a hospital or clinic.

Services for the communities now lacking them will require professional staffing. Doctor Albee's manpower report discusses the difficulty in enticing enough college students into the professional fields to supply our needs. Because of the critical problem of recruitment and distribution of psychiatrists, Daniel Blain has been making a more intensive study of the psychiatric manpower problem. The latest information available to me in rough draft form and, therefore, subject to correction by him reveals that in August of 1958 there were 2,723 psychiatric residents in 245 training centers in this country. This is a gain of 30 per cent (650 residents) over the number training in August, 1956. He reports an increase in the number of programs approved for three years' training in state hospitals, so that in 1958, 51 per cent of state hospitals were approved for three-year programs.

Of the 650 additional residents in training in 1958 as compared to 1956, 250 were in state hospitals and 300 in university hospitals. The federal training centers, largely concentrated in veterans hospitals, were training only 15 per cent of the

total in 1958 as compared to 19 per cent in 1956. This is a most discouraging trend and one that should be studied so that it may be reversed. There is a steady trend toward having larger numbers of residents in training in a particular center. The most rapid rate of increase in residents in training was in the residents who came from foreign medical schools, and this group represented 373 out of the total increase of 650 residents. Thus, more than 50 per cent of the additional persons in psychiatric residencies are from foreign schools, and of the 2,723 physicians in training, 1,066 were from foreign schools. We do not know what proportion of these physicians will remain in the United States after they complete their training. There is also a spottiness in the recruitment of psychiatrists from the various medical schools. There are 77 United States medical schools represented among the persons serving psychiatric residencies, but 27 of these schools supplied 57 per cent of all U.S. graduates in resident training. However, this trend was also present in 1956, because at that time the 27 schools were supplying 56 per cent of the psychiatric residents. Most of the schools supply large numbers of trainees in the middle Atlantic and north-east states.

The research programs in psychiatry and related fields are objects of special study by the Commission. At this time about all we can say is that there is an encouraging trend to more long-term support and to programatic type of support which should make it easier for people to carry on basic research.

The problem of recruiting research workers who must exist from one project application to another with no assurance of renewal of grants is a major handicap in recruitment of people into the research field. Sufficient to say here that it will do little good to encourage the development of research institutes and elaborate research programs unless we train research workers. There is an increasing interest on the part of the NIMH and a few of the foundations in increasing the facilities for training research workers. The next step is to insure some type of reasonably on-going support for the research work these trainees will do, and a support that has a reasonable degree of personal security.

Viewed in perspective, we are encouraged by the changes taking place, inspired by the vast areas of work yet to be done, and humble in our understanding of how little we really know about man's behavior, sick or well. We have studied representative areas of concern to mental health workers and have omitted others because of limits of time and money. From all this we may hope that there will be improvement in the use of available knowledge, but also particular efforts at intensifying the training of research workers and their long-term employment in mental health research.

#### SURGICAL SOCIETY ESSAY AWARD

The Providence Surgical Society announces a Prize Essay award of \$300.00 offered for the best dissertation on:

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The manuscript will not show the author's name but is to be identified by a motto. Accompanying the essay, each competitor will also send a sealed envelope bearing a similar motto outside with his name and address within.

The successful essayist will agree to relinquish all rights and title to his paper.

Unsuccessful essays will be returned to the authors.

The essay must be typewritten doublespaced on standard typewriter paper and should not exceed 10,000 words.

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## THE VALUE OF INFILTRATIONS IN CASES OF SUBACROMIAL BURSITIS DUE TO SUPRASPINATUS TEAR

JOSÉ M. RAMOS, M.D.

The Author. *José M. Ramos, M.D., of Newport, Rhode Island. Senior Physician and Director of Arthritis Clinic, Newport Hospital.*

IN THE COURSE of a physician's practice he will encounter no lesion of the shoulder causing greater pain than acute subacromial bursitis due to supraspinatus tear.

The patient is usually a farmer who has used his shoulders violently in the course of manure spreading or a young laborer who has wrenched his arm in heavy lifting, or perhaps a young housewife who has slipped on the ice and caught the impact of her falling body on a stiffly outstretched arm.

The patient appears usually near to tears, with agonizing pains in the shoulder. The arm is in the position of adduction and held close to the body.

Before proceeding with any form of therapy it is wise to distinguish the various lesions which may precipitate such a painful episode.

Too frequently the busy physician gives the shoulder a casual survey and resorts to the time-honored diagnosis of "bursitis" without actually determining the real cause of pain.

Frequently it may be an acute capsulitis of the shoulder joint with spasms of the muscles of the shoulder girdle and generalized pains of the shoulder that are poorly localized by the patient except for the pains and paresthesiae of the finger tips.

Biceps tendon tear may simulate an acute subacromial bursitis not only in the extent of pain, but also in the difficulty of abducting the arm.

Acromio-clavicular osteoarthritis is probably one of the most difficult conditions to treat. Not actually incapacitating, it is extremely demoralizing in the constant reappearance of pain during the early hours of the morning. Much of the sensitivity remains on hyperextension of the arm during the day.

All these factors, along with acute subacromial bursitis may produce severe pain in the shoulder and need to be given consideration in establishing the diagnosis.

Codman, after whom this syndrome was named, believed that acute bursitis was due to a primary involvement of the supraspinatus tendon with secondary lesions in the bursa.

Trauma with rupture of the supraspinatus tendon is a most frequent cause of this syndrome and, undoubtedly, one of the causes of ultimate disability. Complete rupture causes far more serious symptoms than partial rupture and leads to more frequent permanent disability of the shoulder.

The patient with acute subacromial bursitis has, first of all, a history of trauma to the shoulder. Acute tenderness on gentle palpation is usually noted in the region of the greater tuberosity of the humerus about a finger's width below the acromial process. Any attempt on the part of the patient to abduct the arm causes excruciating pain. The pain is usually so severe that sleep is impossible and large doses of codeine or morphine may be ineffective.

We have found that, in the thirty-six patients with acute subacromial bursitis due to supraspinatus tear whom we have treated, primary consideration should be given to the acute bursal reaction. The treatment of the tendon tear should be secondary and follow at an interval of four to five days.

The technic has been as follows: 2 cc. of Cyclaine,\* 1% is immediately infiltrated into the subacromial bursa together with 2 cc. of Hydeltra-T.B.A.† The arm is placed in a sling and instructions are given the patient not to take the arm out of the sling under any circumstances and even to sleep with the sling applied. Four days afterwards 2 cc. of Cyclaine, 1% and 2 cc. of Hydeltra-T.B.A. are injected into the supraspinatus tendon by entering 2 to 3 cm. below the acromial process at an angle of about 90° to the shaft of the humerus with the arm held in complete adduction.

The sling need not be reapplied, but strict instructions are given that the arm should not be used in more than 15° to 20° abduction from the body except in dressing for at least several days.

On the sixth day, 2 cc. of Cyclaine 1% and 2 cc. of Hydeltra-T.B.A. are again injected into the supraspinatus tendon as described above.

In all our patients we have found that the pain disappeared and there was a return of complete mobility of the shoulder joint at the end of twenty-

\*Trade name for hexylcaine hydrochloride, Merck Sharp & Dohme Research Laboratories, West Point, Pennsylvania.

†Trade name for prednisolone tertiary butylacetate, Merck Sharp & Dohme Research Laboratories, West Point, Pennsylvania.



## THE CASE FOR FORCIBLE HOSPITALIZATION OF THE RECALCITRANT TUBERCULOUS PATIENT\*

STUART WILLIS, M.D.

*The Author, Stuart Willis, M.D., of Chapel Hill, North Carolina Tuberculosis Sanatorium System; North Carolina, Superintendent-Medical Director, Associate Clinical Professor of Medicine, School of Medicine, University of North Carolina.*

TUBERCULOSIS remains a dread disease, and anyone, whether co-operative or not, will likely be bowled over when told he is a victim. His world crashes around him,—he becomes perturbed, and often all he hears at diagnosis is merely that he should enter the hospital precipitately. Yet he sees his responsibilities and is loath to quit his job because it may foretell loss of his part-paid-for home or, at times, even disintegration of his family. He can not know whether welfare aid will be available or sufficient. Furthermore, he may be irresponsible, may have fear that is born of ignorance or prejudice, or submarginal emotional or psychotic background.

Irrespective of underlying character or personality, he becomes a person in deep trouble and stands in need of time to plan and of the friendship of an understanding physician as well as co-operation of visiting nurse, social worker, welfare folk and, if possible, the family. He may have the financial means to meet the issue, but, as all realize, only a small minority does. He needs a sense of security for himself and his family for the duration of his disease. He should be alerted on at least two points: one, that his disease is infectious and may spread to others and two, that nowadays adequate care usually leads to restoration of normal living.

Once he has accepted the diagnosis and knows the consequences of delay in treatment, once his family intactness is assured through welfare or other support, the apparently unco-operative patient often adjusts satisfactorily and accepts treatment. Some who remain at home for treatment will break quarantine, and some among those hospitalized will reject this new mode of living. In any event the tuberculous patient who refuses treatment presents numerous personal and public health problems. Not only does he handle his disease far less well than the average but, by refusing, often threatens the health of the community.

\*Presented at the fifty-second annual meeting of the Rhode Island Tuberculosis and Health Association, at Providence, Rhode Island, May 19, 1959.

But whether the patient is under treatment at home or in hospital, problems arise. At home he may chafe and forsake his isolation. In the hospital he may worry over family, see his life savings dwindle, come across factors such as rooming with an uncongenial stranger or finding food unpalatable; rapport with the nurse may be poor, his doctor may not get around to see him as often as he wishes (all of which is inexcusable and correctible), or the lure of old haunts may pull at him. Many things may send him out before there has been time for adjustment, and he thus becomes an AWOL, which by the way, someone defined recently as standing to mean "After Women or Liquor."

This patient is by no means necessarily recalcitrant. In the scheme which seems to operate with unusual success in North Carolina where there are four hospitals in the state sanatorium system, it is assumed at walk-out that the AWOL patient may well have had problems at home that prevented him from settling down to the cure, may have been homesick or simply have got fed up with life in the institution. His health officer is notified of the walk-out and told that his return will be welcomed—without comment or penalty. This is a key item. Experience shows that in very many instances of return, the patient remains and is co-operative. If he re-enters and walks out again, he is eligible for ready admission into another of the hospitals in the system. If he leaves for the third time, his health officer may well regard him as one who persistently exposes his community to risks. And this officer has a choice of either quarantining him at home or committing him to hospital care. If the home allows essential isolation, sanitation, ventilation and dietary set-up, quarantine is established, and the patient receives care from his physician, or from the health officer. In case home care is inadequate,—which is so very likely because tuberculosis so commonly breeds in poverty—the health officer cites the patient into court.

This latter is also the only course open to the health officer with the patient who refuses to return after any walk-out, or the one who accepts home treatment but persists in breaking quarantine provided, of course, that the disease is still active and communicable. Thus no person is committed except one who has several times refused adequate

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## THE CASE AGAINST COMPULSORY ISOLATION OF THE RECALCITRANT TUBERCULOUS\*

SIDNEY H. DRESSLER, M.D.

The Author, *Sidney H. Dressler, M.D., of Denver, Colorado, Medical Director, National Jewish Hospital, Denver.*

IN MY MIND'S EYE I go back to January, 1957, when the particular subject under discussion was vigorously debated in Denver at a national conference. Actually, what has transpired since then has reinforced me in my opinion that compulsory isolation (of the recalcitrant tuberculous) is unnecessary as well as a misapplication of police authority in the hands of those whose training and backgrounds should make them regard this as repugnant.

I regard compulsory isolation as unnecessary from several points of view, the first being medical in nature. There can be no argument that the cornerstone of tuberculosis control is identification of the infectious case followed by isolation and treatment. If, in addition, it were possible to isolate every infected person who is a tuberculin reactor, we would soon reduce tuberculosis to the status of a minor public health entity, as our veterinary colleagues have done in the control of bovine tuberculosis. This latter approach is impracticable for human disease, since we are dealing with an estimated 50,000,000 reactors in this country, as well as 250,000 active cases. We cannot even begin to think of hospitalizing the active cases, let alone the upwards of 70,000 new cases which develop every year, since there aren't that many beds available.

We are therefore forced to concentrate our efforts in tuberculosis control on the known active cases, and the use of a vaccine limited to predisposed and overexposed groups. Chemotherapy has accelerated an already declining tuberculosis problem, although it still represents the most widespread infectious disease of our time. Mortality rates have fallen spectacularly, but morbidity has fallen slowly and appears to have reached a plateau. It seems to me that the question to be answered is: Would compulsory isolation of the "recalcitrant" appreciably accelerate the steadily declining tuberculosis problem?

\*Presented at the fifty-second annual meeting of the Rhode Island Tuberculosis and Health Association, at Providence, Rhode Island, May 19, 1959.

It was generally conceded at the conference in Denver that recalcitrants represented at most 1 to 3 per cent of the active tuberculous population, though no firm figures were available. The other day I asked Doctor Byington, the head of Tuberculosis Control for the city and county of Denver, for some figures on the occupancy of the locked facilities at Denver General Hospital. Here is his note verbatim: "Since this program (protective isolation) started about three years ago, 19 patients have been placed under quarantine. Most of these patients had had considerable intermittent drug therapy of one kind or another without adequate continuous medical supervision or because of their refusal to remain under medical care." Here in a city of approximately one million population in the metropolitan area—only 19 cases in three years.

Those who are for compulsory isolation admit that the number of recalcitrants may be small in relation to the entire group of the active tuberculous, but argue that the danger to the community from these is greater since they are, in the main, socially irresponsible people. A most interesting biological phenomenon allows us to lay this ghost by the heels. It so happens that if the medical scientist wishes to select resistant strains of tubercle bacilli in the laboratory, he does precisely and deliberately what the recalcitrant patient does unwittingly. He exposes his cultures or tuberculous animals to one drug therapy or to multiple drug therapy of short duration or to inadequate dosages of the various drugs.

As you may have gathered from Doctor Byington's note to me, most recalcitrants have a record of inadequate and haphazard medical treatment and are excreting drug resistant tubercle bacilli. If, as it is claimed, these individuals are significantly contributing to the spread of tuberculosis, we should be seeing new cases of tuberculosis caused by infection with drug resistant organisms. The truth is that we are not seeing these cases in any great or small numbers. The world literature reveals an astonishingly small number of reports of such cases. From personal contact and experience, I have been able to discover seven cases since the generalized use of INH in the chemotherapy of tuberculosis.

No, tuberculosis is not spread by these people excreting drug resistant organisms. If they did com-

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# CASE FOR FORCIBLE HOSPITALIZATION OF THE RECALCITRANT TUBERCULOUS PATIENT

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treatment and who willfully pays no heed to his responsibility for spreading his disease.

What is this man like? His personality and make-up? Psychiatric evaluation reveals that he often possesses intelligence above that required for his occupation; he is unstable in job, marriage, home and social relationships; he exhibits low frustration tolerance and has never learned to put off momentary gratification when it collides with more important issues; that is, he remains immature. This fellow is dependent but is readily irritated when his own whim is crossed; he is quick to become angry at exercise of authority; logically, therefore, doctors and nurses become his pet peeves when in the hospital. He never develops confidence in the staff or a sense of security in the hospital as a place for recovery from a disease he will frequently never quite admit he has. He cannot see his disease as something to treat rather than to run away from. He has small regard for the public weal and little or no sense of the responsibility his infectious disease places upon him. His friendships are likely to be shallow and transitory. Usually, he thinks with his emotions rather than with his brain. Frequently his problem is greatly exaggerated by alcoholism. Recently someone has said: "It is more than a mere incidental circumstance that his is the only group in our society in which tuberculosis is not diminishing."

My associates in psychiatry tell me, on frequent consultation, that this type of patient cannot plan for the future or cannot be realistic; that he is introspective and irresponsible. As to psychiatric care, they advise that "one cannot reason with him or deal with him in the usual psychological sense, cannot impress upon him the dangers of his disease to his family. Psychiatric therapy is usually of little or no avail."

Because of his antisocial attitudes, his hostility and his disregard of sanitation, he will very often flout authority. Hear the true story of one such patient, who, in bravado and disdain of authority, deliberately kissed a five-year-old niece in the mouth, knowing his sputum was positive and then challenged the family to do something about it; this when the family urged his return to the hospital.

## *Problems of Unmitigated Recalcitrant*

What shall we do with this unmitigated recalcitrant? I have four brief comments to make.

1) First, we should recognize that, by temperament and behavior, he offers a greater threat to the health of the community than even the person having the disease and not knowing it, and thus he requires appropriate attention. Certainly, he demands more oversight than the average ex-patient

at home who is careful if not yet well.

Even though we cannot as yet attack the tuberculosis problem *in toto*, we can strive in every community and by every means to combat that fraction of the problem which we do know and especially that which glares at us, and we can strive to break every known contact. It seems only sensible to go after as much tuberculosis in the community as possible—to seek the unknown by intensive and selective case-finding and to hold it unwise to leave alone any known patient who simply chooses to be let alone. "A man's reach," said Browning, "should exceed his grasp, or what's a heaven for." The problem of controlling the spread of this disease is within our reach, if not yet within our grasp. And the challenge stands out boldly to do *all* we can to prevent further infection and disease, whether the scope of our effort covers individuals or groups, small or large. Every case in the community is a potential threat to the people residing there, and tuberculosis on the loose becomes the serious business of all of us.

2) Secondly, this man presents a problem sufficiently serious to justify girding the health officer with proper authority to meet it. Even when the best degree of public health alertness exists; keenness to find new cases, repeated skin-testing of the nonreactor, periodic X raying of the infected and possibly drug treatment for many of these, sometimes the use of BCG for prevention—with all this at hand how, pray, is the health officer to apply these principles when known offenders would nullify his efforts and disregard his orders. Is he able to exercise his responsibility to protect the community's health without authority to do so? Can he prevent or mitigate spread of infection without authority to curb the fellow who wantonly perpetuates this needless and heedless risk? We do not hesitate to restrict the activities or the liberties or the personal freedom of the typhoid Marys or the rare case of smallpox. My information is that in Rhode Island in 1956, no one died of typhoid fever, none of smallpox, 62 from tuberculosis. Should there be restrictions to govern our major infectious disease, even though only a relatively small proportion of the people infected with the germ of tuberculosis develop the disease?

Allow me to recount these facts in a true occurrence: A patient with positive sputum and resistant bacilli refused every encouragement to remain in the hospital, and returned home. In just under twelve weeks, the infant son in the family entered with tuberculous meningitis which yielded resistant bacilli. Of course the child died—died of a species of manslaughter. But to that family an isolation law plus a well child would have been immeasurably preferable to no law to follow and no child to cherish.

Such cases are rare, one may say. They are rare;

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## CASE AGAINST COMPULSORY ISOLATION OF THE RECALCITRANT TUBERCULOUS

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municate their tuberculosis to others, it was at the time when they were excreting susceptible organisms and when they were most likely unknown to the health department. I cannot emphasize too strongly that it is the unknown case of tuberculosis that spreads the disease. I view any cases of tuberculosis developing from this source as a breakdown in our public health methods rather than as a criminal act on the part of the individual concerned.

What of the individual excreting susceptible organisms who not only refuses to be hospitalized but refuses therapy? I do not believe that there is even justification for locking this individual up. There are perfectly adequate prophylactic measures that can be employed to protect the persons in intimate contact with this individual by the judicious use of BCG and INH therapy for the already infected. Public opinion, not force, will persuade the infectee in most instances to accept treatment or to isolate himself until he is non-infectious. Even if he were to refuse to do this, I believe that the risk to the community is small—small indeed compared with the risk to us all of the abuse of authority.

I think we might now profitably turn to a consideration of recalcitrancy and examine wherein we, as professionals charged with the responsibility of tuberculosis control, might be contributing to the incidence of this state. The Colorado Conference demonstrated clearly that recalcitrancy was a psycho-social disturbance which in many instances was induced and aggravated by our attitudes and provisions for control and treatment of tuberculosis. The elements of an adequate tuberculosis control and treatment program were identified and it was pointed out that this might well obviate the necessity for consideration of any compulsory methods.

These elements are as follows:

1. Abolition of the means test where it exists.
2. No legal residency requirements for admission for treatment. There exists the curious paradox in those states which require the establishment of residence before one can be treated, of having those willing to accept treatment refused and those unwilling to accept treatment, incarcerated.
3. A philosophy of treatment which permits patients to feel that their rights and dignity as human beings are respected and that they are worthy recipients of the efforts expended on their behalf.
4. Modern therapy.
5. Freedom of choice of physician and facility.
6. Properly selected cases for home therapy and care.
7. Adequate assistance to the family.

8. Rehabilitation, not merely a program of basket weaving and other diversional activities which masquerade as a rehabilitation program.

9. Psycho-social services which are available not only prior to hospitalization, but during and post-hospitalization.

10. Physician education—much new tuberculosis is being seen first by physicians who are not up to date on current methods of therapy.

11. Adequate public health services such as drugs, nursing, follow-up.

In summary, my position opposing compulsory isolation of the tuberculous is this: Tuberculosis shows a favorable declining incidence without the application of forcible methods of control. If enforced isolation is meant to accelerate this trend, it has not been shown that the recalcitrants are responsible for any significant contribution to the spread of tuberculosis. In our democratic culture the burden of proof is on the authority, not on the patient. The small number of recalcitrants remaining, if adequate control programs were available generally, would also obviate the necessity for compulsory isolation. Recalcitrancy represents a disease state with which tuberculosis may be associated; this may also be said of alcoholism. This state requires the skilled and sympathetic attention of those specially trained in this area of psycho-social pathology. Our inadequacies in this area, as tuberculosis workers, should not cause us to apply force as the only answer.

### SECOND URI PHARMACY CLINIC

The Second Annual University of Rhode Island Pharmacy Clinic will be held at Kingston on November 17 and 18. Members of the Rhode Island Medical Society are invited to attend any of the lectures. Particular attention is directed to the session on the morning of *Wednesday, November 18* at which the following lectures will be given:

#### 10:00 A.M. *Psychotherapeutic Stimulants*

DR. PAUL V. BRADY, *Assistant Professor of Pharmacology, University of Rhode Island*

#### 10:50 A.M. *Recent Developments in the Chemotherapy of Cancer*

DR. C. CHESTER STOCK, *Director of Research, Walker Laboratories of the Sloan-Kettering Institute of Cancer Research*

#### 11:30 A.M. *Antivirus Agents, Including Those for Poliomyelitis*

DR. SIDNEY KIBRICK, *Professor of Medicine, Harvard University Medical School*

# CASE FOR FORCIBLE HOSPITALIZATION OF THE RECALCITRANT TUBERCULOUS PATIENT

*continued from page 652*

at least we do not know the full history of many of the patients. But they illustrate the potentialities—the dangers—and should at least alert us.

3) In the third place, the recalcitrant patient in some areas is allowed to enter or leave the hospital at will, carrying his germs, piggyback fashion, as he mingles with his associates. His characteristic irregular intake of drugs often produces resistant bacilli and allows him to project the added risk of distributing resistant bacilli to his fellow man. In some observations, resistant bacilli have lost their capacity to produce disease in animals. But resistance has been found to vary and fluctuate. And who would willingly risk himself to such exposure, even if such germs were resistant? In fact, the patient whose sputum yields resistant bacilli frequently continues a downhill course to death from his tuberculosis (and his resistant bacilli). The evidence is too great for the infectiousness of this disease to run the risk of having such a patient loose in the community. In my state this practice is prohibited.

Any patient with active tuberculosis may infect others, even though he is not recalcitrant. In this connection, let me cite an experience from North Carolina several years ago when waiting lists abounded. Doctors from one of the institutions cooperated with family physicians and health officers in a plan to give drugs to approximately 150 patients at home, but on waiting lists. In the course of one year, five new cases of tuberculosis developed in those homes (one of them fatal) and no one knows how many became infected or how many may develop clinical disease years later from this infection. Tuberculosis does not blossom out in two weeks after contact, as measles does, but it is *catching*, and I submit that it is potentially dangerous to plant tubercle bacilli in the tissues of any human being. The evidence would appear to show that people who have the disease in active form may spread the germ to others who do not have it.

4) Finally, my state has amended its earlier laws in order better to meet the problems posed by the residual recalcitrant so that:

- 1) Anyone suspected by his physician or health officer of having active tuberculosis, but willfully refusing examination therefor is required to undergo such examination. (To my knowledge no person has yet had to come under the provisions of this law and it would appear that none is being driven underground.)
- 2) Anyone having active tuberculosis and refusing to accept treatment at home under specified conditions or in a hospital for the purpose when home conditions are inadequate

or unsafe, and who, in the judgment of the health officer, constitutes a threat to the health of the community, is arrested and tried in court. If convicted, he is sentenced to the prison division of the State Sanatorium. The minimum sentence depends upon the course of his disease—the medical director having the responsibility to discharge him at any time his tuberculosis has been brought under control and discharge is thought to be safe, or when transfer to other facilities seems proper: the maximum sentence is two years. (The average stay is 11 months.)

This system aims first, to protect the public and second to treat the patient. The sanatorium provides medical care and food: the prison division, the discipline, housekeeping, etc. The light, airy, well-ventilated and well-equipped modern hospital (Figure 1) possesses the features of a security unit, inconspicuous though they are, and provides the basis for adequate care which is rendered by regular staff physicians.



FIGURE 1

How well does the plan work? In it patients may be kept long enough to anticipate restoration of health. During the three years of 1955-56-57 there were: 118 admissions of health law violators, 135 discharges (67 active; 68 inactive). Of the active, all but twelve were discharged by parole to units of the Sanatorium System or other specialized hospitals, chiefly those of the Veterans Administration. The inactive ones were given full and free discharge.

Patients under compulsory medical care frequently develop hostility and refuse to accept medical advice. However, among 257 such patients in this institution major or minor operation was advised in 66 (26% of the discharges) and accepted by 44 or 66.6 per cent. This stands in fairly good comparison with 766 regular discharges in one year among whom operation, recommended to 184 (24% of 766), found acceptance in 168 or 91.3 per cent.

A good number of discharges drift off to other states or areas; a much larger number remain under health department oversight. To date, follow-up records have been maintained locally. Follow-up questionnaires on the 135 patients discharged in this three-year period were recently sent to local



RECENT FOLLOW-UP ON 71 DISCHARGEES						
STATUS AT DISCHARGE	*FOLLOW-UP RESULTS					
	NO RESPONSE	ILL	DEAD			WELL
			TB	OTHER	UNKNOWN	
ACTIVE						
HOME (PAROLE)	1					2
REG HOSP (PAROLE)	4	8 (2)*	5	1		12 (1)*
FINISHED 2 YR TERM	1		1			
INACTIVE	5	2	1 (1)*	4	1	23 (1)*
	11	10	7	5	1	37
						71

\*ALL PATIENTS HAD 12 TO 36 MOS FOLLOW-UP EXCEPT 5 SHOWN IN PARENTHESES. THESE 5 PATIENTS HAD LESS THAN 12 MOS FOLLOW-UP.

CHART 1

health departments. This has yielded 71 returns to date, presented in Chart I.

There was no record on 11. All but five of the remaining cases reported to date had been under observation 12-36 months. Of the 31 inactive cases reported, 23 had been able to return to normal life—74%, 2 were ill, 6 had died—1 from tuberculosis, 4 from nontuberculous disease, 1 cause unknown. Of the 26 active cases on parole, 14 were well—54%, 8 were ill, 7 dead,—6 from tuberculosis, 1 cause unknown.

So in this scheme attention to the recalcitrant rests 1) upon the sound reasoning of protecting the public against this disease by whatever means are necessary after the individual has had every possible inducement to remove himself from contact with the public and to accept treatment, and 2) upon the obvious statistical evidence that health has been restored to a high percentage of these unwilling actors.

VALUE OF INFILTRATIONS IN SUBACROMIAL BURSITIS

concluded from page 649

four hours after the second infiltration into the tendon.

The mean total duration of disability was from seven to eight days, at the end of which time the patient found himself capable of resuming his usual occupation except for those movements which required strenuous exercise of the shoulder joint.

This technic, with the injection of Hydeltra-T.B.A., we consider to be a definite improvement over the application of diathermy, massage, and the administration of analgesics. Analgesics may be given during the first four or five days, which is the most painful period, until the injections of Cyclaine and Hydeltra-T.B.A. have exerted their full effect.

We also believe that this technic offers the patient a minimal period of discomfort with complete rehabilitation of the shoulder joint.

ANNUAL KENNEY CLINIC DAY PROGRAM

At the Pawtucket Memorial Hospital

Wednesday, November 18, 1959

10:30 A.M. AUTOHEMOTHERAPY IN THE TREATMENT OF POST-HERPETIC PAIN. Bencel E. Schiff, M.D., Department of Dermatology, Memorial Hospital; Assistant Professor of Dermatology, Boston University School of Medicine

10:55 A.M. MALROTATION OF THE COLON. Edmund Billings, M.D., Junior Surgeon, Memorial Hospital

11:20 A.M. INTERMISSION

11:30 A.M. VESICO-COLONIC FISTULA COMPLICATING DIVERTICULITIS. Orland Smith, M.D., Chief, Department of Surgery, Memorial Hospital; Richard Rosen, M.D., Resident in Surgery, Memorial Hospital

11:55 A.M. ECZEMA VACCINATUM. William Cohen, M.D., Chief, Department of Dermatology, Memorial Hospital; Earl Kelly, M.D., Chief, Department of Pediatrics, Memorial Hospital; Arture Longobardi, M.D., Department of Medicine, Newport Hospital

12:20 P.M. UNUSUAL CAUSES OF CARDIAC FAILURE. Edwin Lovering, M.D., Department of Medicine, Memorial Hospital; Tadeusz Gorbil, M.D., Resident in Medicine, Memorial Hospital

12:45-1:45 P.M. LUNCHEON

(From the Department of Medicine, Georgetown University)

2:00 P.M. CLINICAL ASPECTS OF HYPOGLYCEMIC THERAPY. John J. Canary, M.D.

2:30 P.M. PRACTICAL CONSIDERATIONS IN THE DIAGNOSIS OF ADRENAL DISEASE. Richard Meyer, M.D.

3:10 P.M. CLINICAL PROBLEMS IN THE DIAGNOSIS AND MANAGEMENT OF ACUTE RENAL DISEASE. William Walsh, M.D.

3:40 P.M. CLINICAL ASPECTS IN THE DIAGNOSIS OF PARATHYROID DISEASE. Marcus Schaaf, M.D.

4:15 P.M. PANEL (Questions from the audience)



## DEPRESSION: TREATMENT OF OFFICE PATIENTS WITH PHENELZINE (Nardil)\*

EDWIN DUNLOP, M.D.

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The Author. *Edwin Dunlop, M.D., of Attleboro, Massachusetts. Assistant Medical Director, Fuller Memorial Sanitarium, Attleboro.*

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IN THE PAST THREE YEARS, a notable series of studies have appeared which dealt with the use of monoamine oxidase (MAO) inhibitors in the treatment of depressive syndromes. The rationale and mechanism of action<sup>1-3</sup> of this new class of drugs have received broad attention in the literature. Several investigators<sup>4-7</sup> have evaluated monoamine oxidase compounds as to their effectiveness in brain metabolism. These compounds influence the concentration and build-up of serotonin, an important factor in controlling nutrition and oxygenation of brain cells.

Sainz,<sup>8</sup> an early worker in this field, first established the clinical usefulness of phenelzine (Nardil) in the treatment of endogenous depressions. Shortly afterwards, his work was confirmed by Saunders,<sup>9</sup> Thal<sup>10</sup> and Furst.<sup>11</sup> More recently Arnov<sup>12</sup> summarized the results of 580 individual cases by sixteen clinical investigators, showing that the administration of phenelzine was beneficial in 84 per cent of non-schizophrenic patients.

Phenelzine, one of the newer MAO compounds is a psychotherapeutic drug, which has also been referred to in the literature and lay press as a psychic energizer.

This report of the use of phenelzine in fifty ambulatory office patients was undertaken for two reasons. First, to determine how successfully patients with mild to severe depression could be managed on phenelzine alone. Secondly, to compare the relative effectiveness of phenelzine and ECT in patients who previously had been treated by electroshock therapy. ECT has been regarded as the most effective form of treatment for depressions for many years. Its value as the treatment of choice was enhanced by the introduction of intravenous anesthesia and muscle relaxants. Subsequently its position as the classic mode of therapy was somewhat challenged with the introduction of iproniazid, a MAO inhibitor. However, reports of liver, blood

and kidney toxicity have limited its usefulness. In the case of phenelzine, all major investigators are in agreement that its spectrum of usefulness is much broader because of virtual absence of major toxicity.

### Method

Each patient in this series had symptoms of mild to severe depression. A diagnosis of depression had been established if the patient showed most or all of the following symptoms: loss of interest; guilt feelings; depressed spirits or withdrawal; crying spells; fatigue, especially in the morning; diurnal variation in mood, worse in the morning, improving as the day wears on; loss of appetite and weight; continuous expression of doubt, hopelessness and futility.

These patients fell into one or another of seven categories of depression recognized by the American Psychiatric Association. But the differential diagnosis of depression had no bearing on the outcome of treatment, except of course in the case of schizophrenia and underlying psychoses, which were not prevalent in this study.

Medication consisted of a 15 mg. tablet administered t.i.d. or q.i.d. as required. After remission of symptoms and stabilization, the dosage was reduced to as low as 15 mg. per day. Optimal maintenance dosage was established on an individual basis.

Phenothiazine derivatives were used to control agitation. In the early stages of treatment, rapid-acting, mood-elevating drugs such as amphetamines, as well as barbiturates to control insomnia were given. These adjunctive measures are neither incompatible with phenelzine nor is there any reciprocal potentiating effect. However, they serve to extend the spectrum of usefulness of phenelzine since such drugs are often necessary for relief of untoward symptoms and behavior at the onset of therapy.

### Results

Judged by the criteria of social response, forty-one patients (82%) experienced complete recovery from their depression. Fourteen of these patients had formerly been treated by electroshock; in each case recovery following phenelzine therapy equaled that effected by electroshock. Two additional patients showed excellent results with phenelzine after one had failed to respond to twenty electroshock treatments and the other to thirty-two.

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\*Nardil (T.M.) is the Warner-Chilcott Laboratories Div. trade-mark for its brand of phenelzine.

Initial signs of improvement were obvious in the first ten days with maximum improvement occurring within the third week. Subjective responses were particularly gratifying since the majority of the patients were well aware of their illness because of its chronicity and recurring tendency. They had sought help earlier in an attempt as many said "to get back on my feet" or "to live again." Elevation of mood and an increase in a feeling of well-being was felt by all. Improvement was also noticeable to others by the patients' increased energy, outgoing nature of activity, more cheerful countenance and weight gain. Symptomatic flare-ups have not occurred in any patients.

### Side Effects

No evidence of toxicity to the liver, blood or kidneys was noted as affirmed previously by other investigators.<sup>8-12</sup> In no case was it necessary to discontinue therapy. The following side reactions were observed but were successfully controlled by adjustment of dosage:

Constipation . . . . .	4
Postural hypotension . . . . .	2
Transient impotence . . . . .	1
Nausea . . . . .	1
Rash . . . . .	1

Also noted were transient atropine-like effects such as dryness of mouth and warmth throughout the body, which are common during the initial stage of treatment, but disappear within a week of continued therapy. Weight gain was not listed as a side effect; in fact it was often a desirable result. No Parkinson-like syndromes were seen.

### Case Histories

The following case histories are typical of those in this series:

*Case No. 1.* When a sixty-two-year-old school-teacher first came to our attention, she complained of increasing fatigue as she neared the end of the school year. After a restless night she had great difficulty arising. She was despondent and experienced crying spells each morning as she contemplated the day's responsibilities. Nevertheless, the patient was anxious to complete the school year, her final one, in order to qualify for retirement benefits. She was given Nardil 15 mg. t.i.d. and Elixir of DexamyI, the latter a recognized mood-lifter with rapid onset of action, but not associated with the usual amphetamine-type jitteriness.

Within seven days the patient experienced a complete reversal of symptoms. She no longer lived in dread of her responsibilities. Her appetite had returned, she gained five pounds and was sleeping much better. She appeared about ten years younger. She is now on a maintenance dosage of one tablet 15 mg. daily, having lost no time from work. The

adjunctive Elixir of DexamyI was discontinued at the end of the third week.

*Case No. 2.* A thirty-eight-year-old woman, suffering postpartum depression, had been in an anhedonic state for the past ten months when she came to our attention. She was unable to care for her baby and was hospitalized at a state institution, where she had undergone twenty-four electroshock treatments. Her improvement was slight and she was manifesting an increased dread of ECT and hospitalization.

This patient was put on Nardil 15 mg. q.i.d. Within five days, her husband reported that she was more alert and communicative than she had been in months. After four weeks of therapy, this patient had complete remission of symptoms. She was able to take care of her baby for the first time in almost a year. She put on eleven pounds and looked well. Subjectively, she reported feeling better than ever. But she is still on maintenance dosage, one tablet 15 mg. daily.

*Case No. 3.* A fifty-six-year-old woman had experienced chronic depression for a period of six to eight months. She was unable to face up to family responsibilities, had crying spells, experienced insomnia, loss of weight and appetite. Encouragement from her husband had no effect.

She had been to several doctors who prescribed for her, but there was no symptomatic improvement. She was finally put on Nardil 15 mg. q.i.d. After the first week there appeared to be little clinical improvement. But at the end of the second week there was a dramatic change. Her facial expression was alert and cheerful and a change in general attitude for the better was noted. Her appetite and interest in things around her returned. Exactly twenty-eight days after treatment this patient stated, "I am as well as I have been in twenty years." Her presenting complaints were gone. She resumed her domestic responsibilities and had gained twenty-one pounds.

### Discussion

Phenelzine must not be confused with tranquilizers since it neither tranquilizes nor is it a muscle relaxant. It alleviates the depressive state but does not act as a stimulant to the point of excitation or jitteriness. Its mode of action is rather corrective of an underlying physiologic derangement of brain function. In the normal patient with no depression excitatory sensation does not occur. Tranquilizers, on the other hand, act mainly at the hypothalamus or thalamus level, and have no influence on the underlying disorder of cerebral metabolism in depression.

Improvement in general health, strength and well-being were manifest very early in the patient's recovery period and it would appear that the mode

*continued on page 671*

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# The RHODE ISLAND MEDICAL JOURNAL

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## MR. FORAND, THE AGED, AND POLITICS

THE FIVE DAYS of hearings in July on H.R. 4700—the so-called Forand Bill which would amend the social security law with an additional tax on both employers and their workers to provide hospitalization and surgical benefits for all persons over the age of sixty-five who are covered under the system—resulted in an overwhelming body of material to discredit such a plan for a federal compulsory health tax plan.

After the hearings even Mr. Forand was convinced that the House Committee would never approve the bill he introduced, and he is reported to have indicated that he was open to any alternative proposal that would work. Since Mr. Forand has cut himself off from his native state and is pretty much a Washingtonian in recent years (he maintains no year-round office in Rhode Island and both telephones listed to his name in the local directory are "temporarily disconnected at the request of the subscriber" as soon as he is elected) it would appear that he should give heed to the alternative proposal of his constituents in Rhode Island.

By the end of 1958 the number of persons in Rhode Island with prepaid voluntary health insurance increased to a total of 706,000, representing 83.1% of the state's estimated current population. These figures are cited by the Health Insurance Institute based on its thirteenth annual survey of health insurance coverage programs of insurance companies, Blue Cross-Blue Shield and other health care plans. The number in Rhode Island reported to have surgical expense insurance at the

end of last year was 597,000, and those protected by regular medical expense insurance, which provides for doctor visits for non-surgical care, increased to 556,000.

With no age limit for either Blue Cross or Physicians Service membership in Rhode Island, approximately 70% of the people who are over the age sixty-five have the hospitalization coverage, and 50% have Physicians Service which provides complete surgical payments for persons in lower income classifications!

But voluntary actions bespeak freedom of mind and freedom of spirit. People acting voluntarily to solve their problems, economic or otherwise, vote with complete freedom. Under a socialistic program where a paternal government controls the services, with politicians showering subsidies on certain groups for vote getting purposes, such freedoms are weakened and eventually destroyed.

As was stated in the report of the federal Department of Health, Education and Welfare in its discussion of the Forand Bill—"The existence of a problem does not necessarily indicate that action by the federal government is desirable." The rapid growth of progressively better voluntary health insurance plans (the new Plan B of Physicians Service, for example), the coverage of Rhode Islanders of all ages and the complete surgical indemnity for those in lower income classifications in Rhode Island, and the outstanding public assistance programs developed in this State offer a constructive approach under the normal incentive of a



free society that guarantees far better medical care than that which would evolve from government compulsion and regimentation.

In our opinion the entire health care movement would get its greatest boost from a Congress that would take effective steps to halt the inflation of the people's money. Inflation, as President Eisenhower stated this summer, in speaking of problems of the aged, is a "robber and a thief that takes the bread out of their mouths, the clothes off their backs, and it limits their access to the medical care and facilities they need."

As a veteran politician Mr. Forand is well versed in the "tricks of the trade." Thus, he indicates that his proposed bill is the best answer to the problem of providing the costs of health care for the over age sixty-five person, but he indicates that he is open to any alternative proposal. The alternative, of course, has to be a compulsory legislative tax plan comparable to his own, for he knows well that the voluntary health insurance movement cannot compete on even terms with a federal tax imposed "give-away plan" that is baited to attract public support.

Likewise, Mr. Forand, to our knowledge, has yet to answer publicly any of the valid criticisms of his legislation. At the hearings on his proposal he tried to divert the discussion of testimony by officials of the American Medical Association on two irrelevant issues, a tactic that resulted in objections by his own colleagues on the committee.

In his solicitude for the aged we have yet to hear an explanation from Mr. Forand why he has no concern for the estimated six million over age sixty-five persons who are not eligible for any social security benefits. Don't they get sick, too, and need hospitalization care? Blue Cross and Physicians Service are taking care of them in Rhode Island whether they have social security credits or not.

Or is Mr. Forand, the politician, holding out on his constituents? He is reported as saying "Some

have criticized this bill because its provisions are modest. They have been deliberately limited to facilitate enactment of this much-needed measure. . . . I feel we've got to creep before we can walk." Modest provisions? What then is the long-range goal ahead for the American people as Mr. Forand and his advisers plan it? A steady "walk" toward all-out socialism under a labor-controlled political party?

Why does Mr. Forand underestimate the cost? He knows well that a government program normally follows the pattern of underestimating the cost (as the Medicare program) and then the government over-commits itself in extending the service and has to pass the additional expense back to the public in increased taxes. Is this the way Mr. Forand wants to halt inflation?

What is Mr. Forand's conception of freedom of the individual? He makes much of the protection of free choice in his proposed legislation, but what kind of a free choice is that which does not allow the individual to say whether he wants this compulsory health insurance, or whether he wants to have his taxes increased to pay for it rather than to purchase protection through voluntary competitive programs? What kind of a free choice is it that limits the selection of doctor, hospital or nursing home?

No government program is justified until the voluntary plans have been found inadequate for the majority of citizens. Rhode Island has proved that the major costs of health care can be secured through insurance protections developed by a free society.

Mr. Forand would do well to urge other states to follow our example, rather than to impose an additional five million dollar tax increase on Rhode Island workers and employers to support a federal program that would dole back a pittance to this state and at the same time destroy our already effective voluntary health insurance program.

## THE COST OF SOCIALIZED MEDICINE

Extension of Remarks of HON. HAROLD R. COLLIER, of Illinois,  
in the House of Representatives, *Wednesday, August 12, 1959*

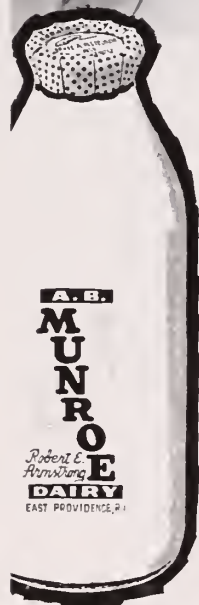
MR. COLLIER. Mr. Speaker, it is a foregone conclusion that Congress will next year wrestle with a bill to provide medical benefits under the social security program. Bringing a bill of this nature before the House of Representatives during

a national election year has rather positive political implications, which only the most naive candidate for public office can deny.

At any rate, I submit herewith an editorial from the *Chicago Tribune* entitled "The Cost of Free  
*concluded on next page*



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Medicine" which affords considerable food for thought, particularly for Members of Congress who might be inclined to view the issue in the light of the elections of November 1960, rather than the cold reality of the experience Great Britain has faced since the inception of its Government-sponsored medical program:

## *The Cost of Free Medicine*

The latest tab for socialized medicine in Britain shows that taxes intended specifically to cover the national health service bill defrayed only 24 per cent of the cost. The remaining 76 per cent must be met by general taxes collected by the Government.

In the 10 years since socialized medicine was inaugurated, costs have risen by one-third, and in the last year hit a record of \$1¾ billion.

We hope that these facts will not be lost upon Congress, where a Democratic group led by Representative Forand, of Rhode Island, is pushing for an extension of social security so that medical care and hospitalization would be provided by the Government to elderly people drawing benefit checks. That this would be another step toward socializing medicine is obvious enough. That it would also embody a cost which eventually would be staggering should be equally plain, although the conclusion is disputed by Forand and those of like mind.

The British experience demonstrates that the initial estimate of cost was far too low, and that the taxes to cover the supposedly free service were correspondingly inadequate. But, once the taxes were fixed, the prospective beneficiaries had a vested interest in keeping the price cheap on what they expected to get. Inevitably deficits accumulated and were passed on to the treasury.

Representative Forand contends that the additional charge for his socialized medicine would be "only" an additional one-quarter of 1 per cent added to present social security taxes falling both on employer and employee. Those who oppose this departure say that it would either break the social security fund or lead to increases in the tax which would soon be insupportable.

The steadily rising membership in voluntary medical insurance plans suggests that the Forand bill is primarily another scheme to corral the votes of a growing segment of the population. We trust that both Congress and the public will consider it in that light and will have the honesty to recognize that only fools expect something for nothing.

*Reprinted from the CONGRESSIONAL RECORD,  
September 3, 1959*

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*Errata:* The caption in the September Journal listed the name as *Albert Henry Miller* under his photo. The correct caption is *Albert Hersey Miller, M.D.*

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SIGN OF GOOD TASTE

## THE YELLOW FEVER AND MOSES BROWN

SEEBERT J. GOLDOWSKY, M.D.

The Author. *Seebert J. Goldowsky, M.D., of Providence, Rhode Island. Surgeon, Miriam Hospital; Assistant Surgeon, Rhode Island Hospital.*

THE VERSATILE Moses Brown, successful Quaker merchant, and one of the four famous Brown brothers of Providence, although not a physician, was much interested in medical matters. Among his voluminous papers in the collections of The Rhode Island Historical Society are copious notes concerning observations on cancer and yellow fever. He is known to have carried on a wide correspondence on the subject of yellow fever, and he devoted himself diligently to investigating its etiology and epidemiology.<sup>1</sup> It was the cause of much suffering and loss of life in seaboard communities during the eighteenth and nineteenth centuries. Local historians, however, were not previously aware that one of his contributions had been published in the medical literature. The discovery of this essay, as is so often the case, was accidental.

Doctor Benjamin Bowen Carter, a graduate of Brown University in the class of 1786, classmate and brother-in-law of the second Nicholas Brown, was ship surgeon on the *Ann and Hope*, built in 1798 for Brown and Ives for the China trade. In his later years, while engaged in the practice of medicine in New York, Carter seems to have had the idea, although never carried out, of writing a history of Rhode Island. In preparation for this never completed work he had set down a number of questions for further investigation. Among these was the following concerning yellow fever:<sup>2</sup>

The yellow fever, was it imported or of domestic origin—in Providence—contagious or not. Pardon Bowen has written an article, in the *Medical Repository of New York* [an incorrect reference] in which he endeavors to prove that it was imported. This essay seems to be a defense of Jos. Nightingale, John Innes Clarke, and Ephraim Bowen for keeping hogs & other nuisances in the lower part of town rather than a candidate investigation of the subject. [Bowen made the following astute observation, although its full significance he could not know: "Laying aside every other consideration, there is one strong fact that proves the yellow fever totally

different in its nature from our country fevers. . . . It is, that frost destroys the yellow fever root and branch, on its first approach." ]<sup>3, 4</sup>


A by-product of the search for his paper was the finding of three<sup>5, 6, 7</sup> others relating to early studies on yellow fever in Rhode Island, including that of Moses Brown:

**Brief Remarks on the Origin of the Yellow Fever in some Parts of the State of Rhode-Island, drawn up by Moses Brown, Esq. of Providence.**

There are some reasons to apprehend that the Bristol fever of 1797, though confidently said, by some, to have been imported, was generated there; or, if brought in the ship *Washington*, was generated on board. I have taken some pains to investigate it, have examined the log-book and journal, and conversed with the keeper, a respectable young man on board during the voyage. The ship *Washington*, William Snell, master, sailed from Bristol to Savannah, in Georgia; from thence she sailed, on the 19th of 7th month (July), for New-York, where she arrived on the 9th of 8th month (August), after 21 days passage, with a cargo of rice and tobacco. She was visited by Dr. Bayley, the Health-Officer; sailed on the 13th day for Bristol, and arrived on the 15th; had been so leaky during her passage from Georgia as to require 200 strokes of the pump every hour to free her. The crew say the yellow fever was not, as they heard of, there during the time of the ship lying at Savannah. The captain and mate took the fever and ague before they came out, and brought it home with them. A young man who ran away from a New-York ship (the *Elizabeth*), which had no person sick on board, took refuge in the *Washington*, and she being in want of hands encouraged him to stay. He was secreted in one of her state-room lockers a number of hours, and came out, sweating profusely, in the evening; he took cold by lying on deck the night he began to complain, and died the 5th of 8th month (August) seventeen days after sailing. Another of the hands was sick when they got to New-York, and was taken to the Hospital, by the advice of Dr. Bayley, as having erysipelas. He died about thirteen days after. Another was taken, labouring in the hold, on the 13th, in unloading at Hellgate. He came to Warren, and died

*concluded on page 666*





it  
started  
as a  
"cold"...

to prevent the sequelae  
of u.r.i. ... and relieve the  
symptom complex

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<sup>1</sup>. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

## YELLOW FEVER AND MOSES BROWN

*concluded from page 664*

in his father's family on the 20th. Another young man (Bradford) was taken ill, labouring in Bristol harbour to get the ship off the ground, and lay sick at his father's house, a mile out of town, but recovered. None of these two families, nor any other person, took the fever; nor was it communicated from the washing of the clothes of any of the people who came home. Hence it would seem, if these had the yellow fever, it was not contagious, either from them or their clothes. It was said to have been taken from some light sails which the sail-maker took from the vessel. The crew say these sails were daily hoisted, were wet and dried again, after the ship left New-York. It seems unlikely that these sails (never, as they say, lain on by the sick) should communicate the disease, while the very clothes and bodies of the sick who came home in her did not, though attended by all their friends, without fear or suspicion of contagion. It was also suggested that the ship's bilge-water gave the neighbours the fever; but her leaking must have prevented much collection of filth; and those who saw her pumped told me the water was white, like sea-water, she leaked so much: and though the subject is too lengthy for discussion here, I add, there are some of the most judicious people in that town consider the fever (of which eighteen died and one recovered) to have originated in Bristol, while others say it was imported in the ship above-mentioned: so nothing can be absolutely determined by the opinions there, further than as to its contagiousness, if those I mention had it, whose families had it not.

Of the first nine who died in Bristol, there were none communicated it to any others; but the person who recovered is said to have given it to a native, or very long resident black woman, who watched with him. She, however, had it, and died; by which many considered it to have been contagious: yet she might have taken it from the same source as others there did; for the next woman who had it, and who died on the 1st of 10th month (October), is said to have been no where to take it. Many were on board this ship at Bristol, and unloaded her, but have not had the yellow fever. Two that worked on board have had a bilious fever similar to that of the young man, my informant, and recovered, though only one out of eighteen who had the yellow fever in town survived; by which it appears that the fever taken by fatigue on board was much more favourable than that of the people in town, who could give no account how or where they got it, which shews a bad state of the air, and is thus accounted for:—They raise large quantities of vegetable roots, as onions, beets, parsnips, &c. and collect large heaps of manure. In that year, near where

the fever commenced, there was a large and very offensive pile of putrid fish and other matters heaped up to rot for manure; and an offensive old distillery, that had not been wrought for a number of years, at the same wharf where the ship lay; from whence, it is probable, the smell proceeded that was attributed to the bilge-water, which, as the ship, though light, leaked much, could not smell so offensively.

The mortality in this town, for the years 1795, 1796, and 1797, ought to excite the inhabitants to more attention in investigating the cause, and, if possible, to remove it: for its natural situation one would suppose to be as healthy as that of any town in the State.

I find, by a list of individuals, kept by a person of observation there, Daniel Bradford, Esq. whose son was my informant before mentioned, and whose journal I examined at his father's house, that forty-eight persons died in 1795, sixty-three in 1796; and from the 7th of 1st month (January) to the 27th of 10th month (October), inclusive, being only nine months and twenty days, fifty-five persons died there, of whom ten were males, from thirteen to seventy-three years of age, and eight females, from thirteen to forty-seven, in the year 1797. This year, 1798, I believe it has been healthy there as well as at Providence. [*Further extracts from Mr. Brown's account of the Yellow Fever will appear in some of our future numbers.*]\*

\*A search of subsequent issues failed to reveal any further contributions by Moses Brown.

## REFERENCES

- <sup>1</sup>Goldowsky, Seebert J.: The Beginnings of Medical Education in Rhode Island, R. I. Med. J. 38, 496, et. seq., 1955
- <sup>2</sup>Kenny, Robert W.: Benjamin B. Carter, Physician Extraordinary, Rhode Island History 16:97, 1957
- <sup>3</sup>Bowen, Pardon: Observations on the Origin and nature of the Yellow Fever, which Prevailed in Providence, Rhode Island, in the summer of 1805. In a letter to James Hardie, Esq. Secretary to the Board of Health, N. Y. from Dr. Pardon Bowen, American Medical and Philosophical Register 4:331, 1814
- <sup>4</sup>Bowen, Pardon: Observations on the Origin and Contagious Nature of the Yellow Fever, as it has prevailed in Providence, Rhode-Island, and other Parts of the United States. In a Letter to David Hosack, M.D. New-York, from Dr. Pardon Bowen, Physician, Rhode-Island, American Medical and Philosophical Register 4:341, 1814
- <sup>5</sup>Wiley, Aaron Comstock: A Short Account of the Yellow Fever which Appeared on Block-Island, in the Summer and Autumn of 1801. By Aaron Comstock Wiley, Resident Physician there. Communicated by Dr. M. Foot, Medical Repository 6:123, 1803
- <sup>6</sup>Wheaton, Levi: A Brief Account of the Yellow Fever which has appeared at different times in Providence, (R. I.) with a Topographical Sketch of that Town, and some Reflections on the Use of Mercury. By Dr. L. Wheaton, Physician at Providence, Medical Repository 10:329, 1807
- <sup>7</sup>Brown, Moses: Brief Remarks on the Origin of the Yellow Fever in some Parts of the State of Rhode-Island, drawn up by Moses Brown, Esq. of Providence, Medical Repository 3:267, 1800



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*References:* 1. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Bonica, J. J.: in *Drugs of Choice*, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in *Current Therapy*, Saunders, Phila., 1958, p.78. 6. Bickerman, H. A.: in *Drugs of Choice*, Mosby, St. Louis, 1958, p.547.

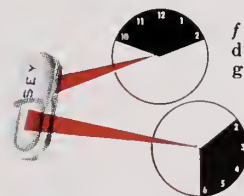
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## LEGAL STATUS OF ARTIFICIAL INSEMINATION

### An Opinion by Legal Counsel of the Society

EDWARDS AND ANGELL

THERE IS NO statutory or case law on the subject in this state. Artificial insemination is so new that it has not acquired any settled legal status. We have been able to find only four or five cases in other jurisdictions involving artificial insemination and not one of these cases was decided in a court of last resort. Therefore, at this time, it is only possible to suggest some of the consequences which may follow when a child is born by virtue of artificial insemination. These consequences may be criminal or civil and will depend on whether artificial insemination is accomplished with the husband's sperm (AIH) or with the sperm of a third party donor (AID). Our conclusions are summarized at the end of each discussion.

#### *Possible Criminal Consequences*

*Adultery.* In the case of AID there is a split of authority on whether the crime of adultery has been committed. Whether the crime has been committed depends on whether normal sexual intercourse is a necessary element of the crime. The Rhode Island statute on adultery (R.I. General Laws, 1956, Sec. 11-6-2) does not define the word and there has been no Rhode Island case on the subject. The popular American view is that sexual intercourse is a necessary element of the crime, so the Rhode Island Court might follow this view. However, a few courts have held that sexual intercourse is not necessary and adultery results from artificial insemination where a donor's sperm is used. When this view is accepted, the husband's consent to the insemination is immaterial since consent to a crime is ineffective. If the crime of adultery has been committed, then the wife is guilty of adultery, and the doctor, nurse, and donor *as well* may be guilty as accessories.

The text authorities seem to indicate that in the case of AIH the crime of adultery has not been committed.

*Fornication.* The crime of fornication is not defined by the Rhode Island statute (R.I. General Laws, 1956, Sec. 11-6-3). However, it is generally agreed that sexual intercourse is a necessary element of this crime and therefore neither AID nor AIH would result in the commission of this crime.

*Forgery.* Falsely making or procuring to falsely make public records is a crime (R.I. General Laws, 1956, Sec. 11-17-1). Also the giving of false information to the Registrar of Vital Statistics is a

crime. (R.I. General Laws, 1956, Sec. 11-18-2). Therefore, if a child is born as a result of AID and the name of the husband is placed on the birth certificate as the father, a crime has been committed. The husband, the wife and the doctor may all be guilty of this crime.

*Accessory.* Any person who aids, assists, abets, counsels or procures another to commit a crime is held responsible for the crime committed as an accessory (R.I. General Laws, 1956, Sec. 11-1-3). Therefore, if any of the above crimes have been committed in the case of AID or AIH, the doctor, nurse, husband or donor could be prosecuted as accessories.

#### *Conclusion*

From the above discussions, several crimes can, in our opinion, be a by-product of artificial insemination, at least, in the instance of AID. Since the law is not settled in this state, all parties involved are risking criminal prosecution if the fact of artificial insemination is established.

#### *Possible Civil Consequences*

*Illegitimacy.* In the case of AIH, the authorities are in agreement that the child would not be illegitimate since he or she would be born in lawful wedlock by virtue of the sperm of the husband. However, in the case of AID, the authorities are likewise in substantial agreement that the child would be illegitimate.

Several consequences, of course, follow if a child is illegitimate. Unless specifically named in the will, the child could not inherit from the husband, would not be entitled to support from the husband and in the event of a divorce or separation, the husband would not be entitled to custody as opposed to the wife who is the natural parent. In short, the child could not be considered as the lawful child of the husband for any purpose. The only way out of this dilemma appears to be to have the husband legally adopt the child, but, of course, that would bring the artificial insemination to light. The donor would be the natural parent of the child but as to him the child would still be illegitimate and would have no rights.

*Negligence and malpractice.* In the case of AIH, the possibility that the doctor would be charged with malpractice or negligence is not serious. How-

*continued on page 670*

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ever, in the case of AID, if the child is born deformed or mentally retarded, the doctor would, in our opinion, be subjecting himself to the possibility of a malpractice suit. The husband and wife may well contend that the doctor did not use sufficient care in choosing the donor or administering the insemination.

*Divorce.* Adultery is a ground for divorce in Rhode Island so that to the extent that AID is deemed to be adultery, a ground for divorce has accrued upon the insemination. It is probable that even though the crime of adultery has not been committed, the courts would consider AID sufficient proof of adultery for purposes of divorce on the petition of the husband. However, if the husband lives with his wife after knowing of the insemination, this would constitute condonation by the husband and would serve as a defense in a divorce action.

*Criminal Conversation.* This is the civil remedy for a husband or wife when the other spouse has committed adultery. Again, if artificial insemination is regarded as adultery, the donor or doctor may be liable in a civil suit for criminal conversation. How-

ever, if the husband has consented to artificial insemination, it is likely that a court would hold that he was estopped and could not bring an action.

### CONCLUSION

This enumeration of possible civil consequences does not purport to be all inclusive. However, the consequences enumerated are sufficient to indicate that artificial insemination creates grave legal problems. Very few of the problems have been answered and therefore artificial insemination by the use of the husband's sperm or a donor's sperm is a calculated risk. No legislation has been enacted in this field. Legislation is probably the only way to settle the status of artificial insemination at this time since it will take many years before there are enough court decisions in this area from which concrete rules can be derived.

Some of the text authorities which discuss the legal problems of artificial insemination are:

*Recent Decisions*, 43 *Georgetown L. J.* 517 (1955);

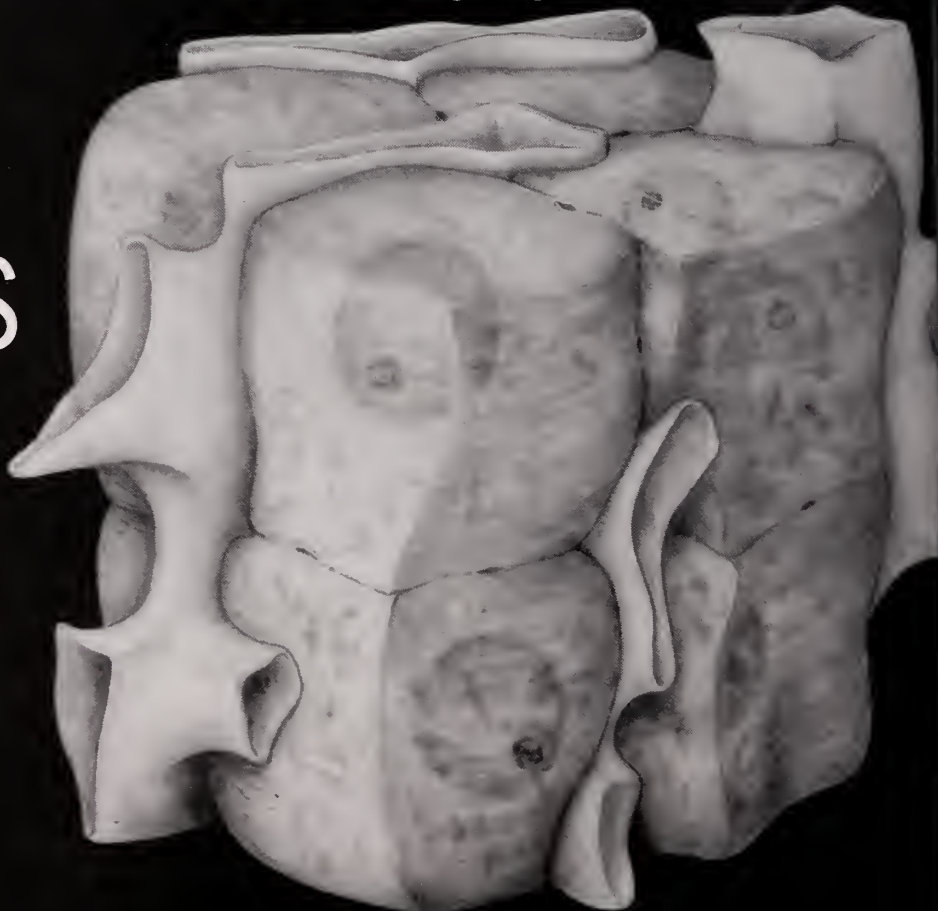
*Gittinger, Artificial Insemination: Its Place in Washington Law*, 32 *Wash. L. Rev.* 280 (1957);

*Comment, Legal Problems of Artificial Insemination*, 39 *Marquette L. Rev.* 146 (1955);

*concluded on page 681*

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# DEPRESSION: TREATMENT OF OFFICE PATIENTS WITH PHENELZINE

*continued from page 657*

of action is quite different than that of a CNS stimulation. The latter type of drug occasionally provides a transient stimulation in mild to severe depressions, but has no basic effect on the underlying disorder of cerebral metabolic function. Phenelzine is not purely stimulating in character, but actually encourages cerebral metabolism and physiological changes in the brain not associated with CNS stimulants, amphetamines or tranquilizers.

Of special interest in this group of fifty patients were fourteen who had previously received electroshock therapy with good results. However, with the recurrence of their symptoms of depression, they manifested increased apprehension of undergoing further electroshock therapy. They were most receptive to drug therapy, in this case, phenelzine. On the basis of this limited but striking body of experiences with phenelzine, I am inclined to subscribe to the view of Sainz that this drug "bids fair to reduce or supplant the use of electroshock."<sup>8</sup>

With phenelzine therapy recovery from the depressive symptoms is maintained over prolonged periods. As was evident in case after case, the de-

pression itself was corrected and the patients were restored to their former self. Once more they became able to accept the challenges of life. Phenelzine seems to be especially useful in non-hospitalized, ambulatory patients with symptoms of depression. Increasing the dosage does not appear to shorten the latent period of about seven days.

## SUMMARY AND CONCLUSION

Depression is defined symptomatically as a state of sadness, apathy, inertia, self-reproach, psychomotor inhibition, insomnia, guilt feelings, and loss of weight and appetite. Of a group of fifty ambulatory office patients who were treated with phenelzine, 41 (82%) experienced complete recovery from depression. Included in this improved group were fourteen patients who previously had been treated successfully with electroshock and two in whom it had been unsuccessful. Phenelzine appeared equally as effective as electroshock in the treatment of depression.

## BIBLIOGRAPHY

- <sup>1</sup>Brodie, B. B.; Pletcher, A., and Shore, P. A.: Possible Role of Serotonin in Brain Function and in Reserpine Action. *J. Pharmacol. and Exper. Therapy*, 116:9, 1956
- <sup>2</sup>Chessin, M.; Dubnick, B.; Kramer, E. R., and Scott, C. C.: Modifications of Pharmacology of Reserpine and  
*concluded on page 693*

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1. Innerfield, I.: Clinical report cited with permission  
2. Clinical report cited with permission



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## THE STATE'S REHABILITATION PROGRAM FOR CHRONIC ILLNESS AND DISABILITY

GEORGE F. MOORE, JR.

The Author, *George F. Moore, Jr., of Providence, Rhode Island, Chief, Rhode Island Division of Vocational Rehabilitation.*

**D**URING THE PAST few years a relatively small state agency, in existence since 1921, has expanded to assume a major role in the community's efforts to deal with the mounting numbers of chronically ill and disabled persons. The Rhode Island Division of Vocational Rehabilitation, a unit of the State Department of Education, is presently staffed, financed and generally organized to provide complete restorative services to all whose impairments are such that they are handicapped in making a suitable adjustment to work. "Work" includes employment in the competitive labor market; practice of a profession; self-employment, homemaking, farm, and sheltered employment and home-bound work.

The restorative services which the Division of Vocational Rehabilitation provides are:

1. A general medical examination in each case to determine the extent of disability, to discover possible hidden or "secondary" disabilities and to determine work capacity. Examinations by specialists are often necessary. The individual has choice of his own physician and the physician's fee is paid by the division.
2. Individual counseling and guidance in every case to help the disabled person plan the right job objective. Vocational diagnosis often includes psychological and aptitude testing.
3. Medical, surgical, psychiatric, and hospital care as needed to remove or reduce the disability. Choice and preference of the person for his physician and continuity of care are allowed. Fee schedules are in effect which approximate Plan A of Physicians' Service. Hospitals are paid on a state-approved per diem rate.
4. Artificial appliances, such as limbs, braces, hearing aids, eyeglasses and the like, which are needed by the person for employment or by a housewife for caring for children and home.

5. Training in schools or colleges, by tutor, by on-the-job training, by correspondence courses, or by other facilities to enable the individual to do the right job well.
6. Maintenance and transportation, if necessary, while the disabled person is undergoing treatment and training.
7. Occupational tools, equipment, and licenses.
8. Placement on the right job.
9. Follow-up after placement to make sure that the rehabilitated worker and his employer are satisfied.

Among the chronic conditions considered selectively by the agency to be within the scope of rehabilitation are arthritis, cerebral palsy, epilepsy, birth defects, hemiplegia, cardiovascular disease, mental illness, tuberculosis, glaucoma and other eye conditions, hearing defects, speech and dental defects, amputations, ununited fractures, osteomyelitis and poliomyelitis. Chronically ill and disabled persons who have been accepted for service may be given all of the services they need, including those that eliminate or ameliorate handicapping conditions. In some cases the only service needed may be physical restoration in addition to counseling in relation to vocational adjustment.

The Division of Vocational Rehabilitation's program does not have the responsibility for furnishing all kinds of medical services for all kinds of conditions; its responsibilities are limited to the treatment of conditions which have resulted in a substantial handicap to working and which directly affect the employability of its clients.

The division retains a physician, on a part-time basis, who gives medical consultation to staff members for each case in which physical restoration services are considered or provided.

Requirements for furnishing physical restoration, in addition to the basic eligibility conditions for Vocational Rehabilitation, are, (1) The clinical status of the individual's disabling condition must be stable or slowly progressive; (2) The physical restoration services may be expected to eliminate or substantially reduce the handicapping condition within a reasonable period of time; and, (3) The individual must be found to be in need of financial assistance in meeting the costs of services. Medical indigency

*continued on page 676*



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# STATE'S REHABILITATION PROGRAM FOR CHRONIC ILLNESS AND DISABILITY

*continued from page 674*

is determined in each case as most patients the division serves have marginal or submarginal incomes; Vocational Rehabilitation is not a "welfare" program.

Working closely with Social Service departments of Rhode Island's hospitals the agency co-ordinates and expedites rehabilitation services to chronic disease patients. Full-time Vocational Rehabilitation counselors are assigned to Our Lady of Fatima Hospital, Rhode Island Hospital, and Butler Health Center. Part-time affiliations of counselors are in effect in all of the hospitals throughout the state.

Many physicians, aware of the program's help for patients of theirs unable to pay for the restorative services they need, refer directly to the division which is located in the Roger Williams Building, Hayes Street, Providence. As examples of this kind of association and the resultant benefits to patients the following case histories are presented:

A forty-five-year-old mother of three children was referred to the Division of Vocational Rehabilitation by her physician, a cardiac specialist and surgeon. The patient had both mitral and aortic stenosis and insufficiency showed marked dyspnea on exertion, had a chronic cough and frequent dizzy spells. Because of her condition, she was unable to do any of her household duties and was bed bound

when interviewed by the rehabilitation counselor. The counselor determined that the woman's husband, a mechanic, was not financially able to underwrite the costs of the needed surgery and hospitalization.

The patient was extremely apprehensive realizing the risk involved in aortic surgery. The counselor working with the doctor visited her a number of times and while he did not minimize the surgical risk he was able, through supportive counseling, to help the patient better to accept the necessity of it. As a result, she entered the hospital more adequately prepared for the surgery.

The operation, employing the open heart technique, was performed on May 7, 1959. Both aortic stenosis and mitral stenosis were corrected at the same time. It is interesting to note her physician said after the surgery, "this is perhaps the most extensive open heart surgery for acquired valvular disease ever performed on one patient on one occasion." The Division of Vocational Rehabilitation underwrote cost of all expenses over and above Blue Cross and Physicians Service coverage including special nurses needed following surgery.

Another, an in-patient of a local hospital, a sixty-one-year-old widow, was referred by her physician to the Division of Vocational Rehabilitation. Her hospitalization was the result of an accident in her home in which she sustained a malleolar fracture of the right ankle and fracture of the left patella. Prior

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Calcium (as CaHPO <sub>4</sub> ) . . . . .	122 mg.
Phosphorus (as CaHPO <sub>4</sub> ) . . . . .	0.1 mg.
Boron (as Na <sub>2</sub> B <sub>4</sub> O <sub>7</sub> · 10H <sub>2</sub> O) . . . . .	1 mg.
Copper (as CuO) . . . . .	0.1 mg.
Fluorine (as CaF <sub>2</sub> ) . . . . .	1 mg.
Manganese (as MnO <sub>2</sub> ) . . . . .	1 mg.
Magnesium (as MgO) . . . . .	5 mg.
Potassium (as K <sub>2</sub> SO <sub>4</sub> ) . . . . .	0.5 mg.
Zinc (as ZnO) . . . . .	

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to this mishap, she had been gainfully employed for over six years as a carder and wrapper in a jewelry firm.

This woman was the type of individual who took great pride in being independent and managing her life so that she would not be a financial burden on her married children. In 1956, her husband died of cancer and his extended illness drained the couple of whatever savings they had managed to put aside. After his death she frugally, but comfortably maintained herself in her own home on a very marginal income.

At the time she was referred for rehabilitation she was physically unable to work and emotionally distraught because of her altered circumstances.

Upon her discharge from the hospital, the division's counselor arranged an intensive program of physio, occupational and supportive therapy for a period of two months at the Rehabilitation Clinic in Our Lady of Fatima Hospital.

Although the woman was very fearful that she would have great difficulty walking again and also faced the prospect of climbing stairs as well as crossing streets if she returned to work, she entered into her rehabilitation program with the guidance and assistance of the counselor and in two months she was discharged and was able to return to former occupation.

The Division of Vocational Rehabilitation, in addition to its program for the restoration of the disabled to work, is responsible for the administration of the disability benefits program as it affects Rhode Island workers. Under the 1954 and 1956 amendments of the Old-Age and Survivors Insurance Act (Social Security), the State of Rhode Island entered into an agreement with the Federal Bureau of Old-Age and Survivors Insurance to adjudicate claims of disability for persons who apply for such benefits. These include:

1. Disabled workers, fifty years of age or older, who apply for monthly Social Security disability payments.
2. Disabled workers who are not yet fifty years of age who apply to protect their rights to future benefits for themselves and their families by applying to have their Social Security records frozen.
3. Disabled children of deceased insured workers and those of retired insured workers who apply for benefits, if they are eighteen or older and have been disabled since before their eighteenth birthdays.

The applicant is required to obtain, at his own expense, medical evidence showing the extent of his disability.

*concluded on page 691*



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Cutaneous or other objective sensitivity reactions are rare, as demonstrated in a large scale evaluation of clinical toxicity.<sup>2</sup> Also minor subjective reactions are less likely to develop when the recommended dosage is used.<sup>2</sup>

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1. Editorial, New England J. Med. 258:48, 1958.

2. Vinnicombe, J.: Antibiotic Med & Clin. Ther. 5:474, 1958.

3. Sheth, U. K., et al.: Ibid., p. 604, 1958

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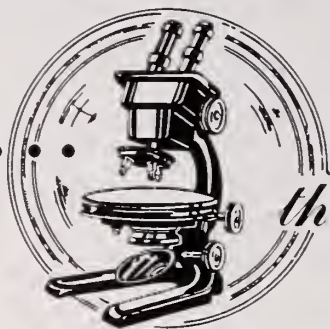


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THROUGH .

*the Microscope*

### ***New England Postgraduate Assembly — November 3-4-5***

The Seventeenth Annual New England Postgraduate Assembly, a three-day program of postgraduate medical courses for practicing physicians, will be held at the Statler-Hilton in Boston, Massachusetts, November 3, 4 and 5, under the auspices of the six New England state medical societies and chapters of the American Academy of General Practice.

Doctor Joseph R. Frothingham, of New Bedford, representing the Massachusetts Medical Society, is chairman.

In addition to morning clinics at Boston hospitals, the program will include lectures, panel discussions, clinicopathological conferences, luncheon symposia, medical films and scientific and technical exhibits.

A special program for wives of attending physicians has been arranged.

### ***Health Insurance Benefits Show Continuous Improvement***

Benefit provisions in health insurance policies covering hospital and surgical care have been improved steadily throughout the 1950's, the Health Insurance Institute reported recently.

In 1951, a survey of some 101 insurance companies showed that the top daily hospital allowance offered by 89% of these companies averaged \$8 or less, the Institute said. At that time, only 5% of the total number of companies surveyed offered a policy paying \$10 a day or more.

Three years later, with the added experience which insurance companies gained with this form of health insurance protection, the situation had changed. In 1954, a survey of 186 insurance companies disclosed that 72% offered policies with hospital benefits of \$15 a day or more. Some 11% offered policies at \$20 a day and 4% offered \$25 daily or more. Only three of the companies surveyed that year had a maximum daily hospital benefit of \$8.

The trend toward more adequate daily hospital benefits had continued, the Institute found.

A recent review of 188 insurance companies indicated that 93% offer maximum daily hospital benefits of \$15 or more. This same analysis, reported the Institute, showed that 32% of the surveyed companies offer \$20 a day or more, and 17% of the companies offer upwards of \$25 a day. In addition, at least three companies have policies with hospital benefits of \$30 a day or more.

The maximum duration of stay in the hospital also has been extended, the Institute stated.

The broadening of benefits in available health insurance policies also holds true for surgical expense coverage, said the Institute. Among 183 companies surveyed in 1954, some 16% offer maximum surgical benefits of \$300 or more. Currently, of 188 companies analyzed, 72% offer a surgical maximum of \$300 or more.

### ***Cerebral Palsy Related to Birth and Pregnancy Complications***

Complications of birth and pregnancy play major roles in the onset of cerebral palsy, a disease which afflicts over half a million Americans. Evidence pointing to this close association between birth and pregnancy problems and cerebral palsy is presented in a recent issue of *PATTERNS OF DISEASE*, prepared by Parke, Davis & Company for the medical profession.

In seven out of every ten persons with the disease, brain damage occurs either before, during or just after birth, the publication states.

What causes the brain damage? Possible factors cited are severe infections, oxygen deficiency and vascular injuries suffered during birth. Moreover, cerebral palsy occurs more frequently in twins and other multiple-birth babies than in the general population.

### ***A.M.A. to Hold 13th Clinical Meeting in Dallas***

The American Medical Association's 13th clinical meeting December 1-4 in Dallas, Texas, will draw some 3,500 physicians, mainly from the southern and southwestern states.

Planned in co-operation with Dallas physicians, the meeting is designed to help the family physician

meet his daily practice problems.

Among the subjects to be discussed on the scientific program are soft tissue injury; whiplash injuries of the neck; diabetes; heart murmurs in children; new laboratory procedures; new resuscitation techniques; premarital and marital counseling, and the problem child.

The scientific program, including lectures, symposiums, medical motion pictures, color television, and nearly 100 scientific exhibits, will be held in Dallas Memorial Auditorium. Industrial exhibits will number 251.

#### *VA to Aid Research on Multiple Sclerosis*

Information to aid research on multiple sclerosis and other diseases will be provided by a new Veterans Administration research division in Washington, D. C. The new geographic epidemiology division, just established in the Research Service of the VA Department of Medicine and Surgery, will use data-reporting systems of the agency's 170 hospitals to compile information on geographical and occupational distribution of little-understood diseases.

The VA projects will be unique in that nowhere else are available the extensive medical records of the sort needed for such research on a major scale.

The division is expected to furnish much valuable information not otherwise available, since the VA's hospitals can supply data in volume, on a nationwide basis, and in a standard way.

#### *Clafin Company Established in New Quarters*

The Clafin Company, one of the state's oldest surgical, medical and hospital supply houses, has moved from Mathewson Street to a new location at One Acorn Street — site of the former Nicholson File building. The new location affords ample parking for the convenience of physicians.

#### LEGAL STATUS OF ARTIFICIAL INSEMINATION

*concluded from page 670*

*Johnston, Natural Law and Artificial Insemination, 5 Catholic U. L. Rev. 189 (1955);*

*Decisions, Family Law: Legitimacy of Child Conceived by Artificial Insemination, 30 N. Y. U. L. Rev. 1016 (1955);*

*Notes and Legislation, Legal and Social Implications of Artificial Insemination, 34 Iowa L. Rev. 658 (1949);*

*Holloway, Artificial Insemination: An Examination of the Legal Aspects, 43 A. B. A. Jour. 1089 (1957).*

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PATHIBAMATE-400 and PATHIBAMATE-200 are indicated for duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

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**Administration and Dosage:** PATHIBAMATE-400—1 tablet three times a day at mealtime and 2 tablets at bedtime.

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Adjust dosage to patient response.

**Contraindications:** glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.



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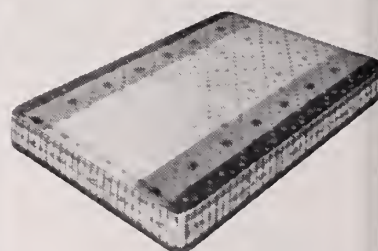
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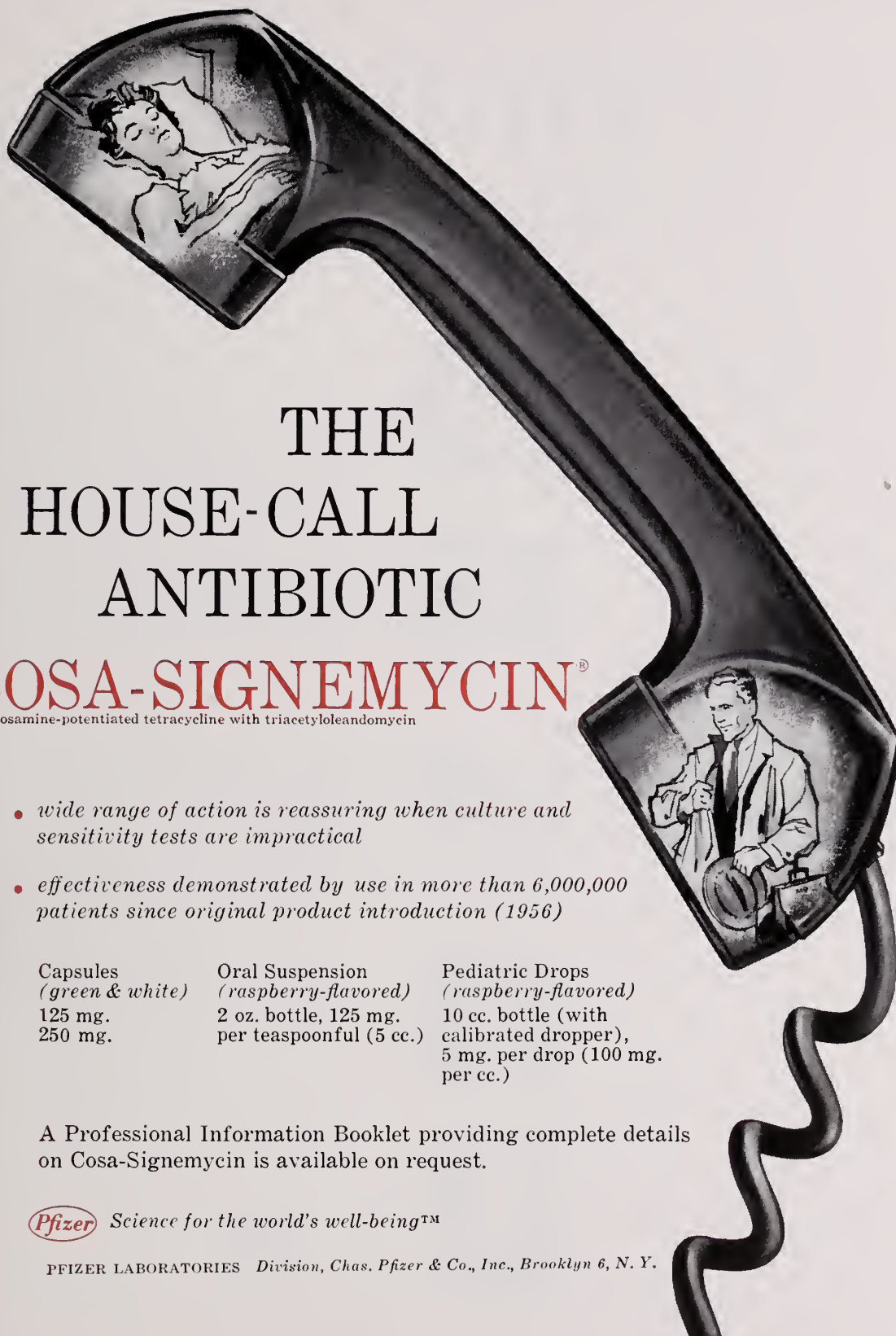
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VIGRAN CHEWABLES *taste like candy*, but contain *no ingredients harmful to teeth*.

Important, too, is that VIGRAN CHEWABLES *dissolve easily* in the mouth and *smell good*. These advantages will also appeal to your elderly patients. And VIGRAN CHEWABLES provide at least 125% of the minimum daily requirements for vitamins A, D, B<sub>1</sub>, B<sub>2</sub>, niacinamide and C, and significant amounts of other essential vitamins.

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## THE WASHINGTON SCENE

(A Summary Prepared by the Washington Office  
of the American Medical Association)

CONGRESS THIS YEAR failed to take final action on any legislation of major interest to the medical profession except for the annual appropriation for medical research.

However, work was started on three measures of particular concern to physicians — the Forand, Keogh-Simpson and international health research bills. Showdown votes on them are probable next year. If there are not votes next year, they will die and must be reintroduced in 1961 if they are to be considered further by Congress.

The House Ways and Means Committee held hearings on the Forand bill, but deferred showdown voting on it until next year. The legislation—which is vigorously opposed by the medical profession, other groups on the health team and the Eisenhower Administration — would provide hospital, surgical and nursing home care for federal Social Security beneficiaries. Social Security taxes would be raised to help finance the expensive program.

The Keogh-Simpson bill, after being approved by the House, was left hanging in the Senate Finance Committee. The Senate committee held two sets of hearings. It could vote early next year on the legislation which would grant income tax deferrals to physicians and other self-employed persons as an incentive to invest in private pension plans.

Chairman Oren Harris (D., Ark.) postponed until next session a vote by the House Commerce Committee on the Senate-approved international medical research bill because of a backlog of more urgent measures requiring committee action this year. He said that "a diligent effort" would be made during the recess to clarify a number of points at issue revealed in testimony before his committee.

The bill calls for an annual 50 million dollars authorization to finance a new national institute of health to foster international medical research programs and co-operation. The Administration opposes some of its provisions.

President Eisenhower and Arthur S. Flemming, secretary of Health, Education and Welfare, made clear that they didn't feel bound to spend the additional 106 million dollars which Congress voted for medical research. Congress raised the 294 million dollars requested by the President to 400 million.

Mr. Eisenhower expressed concern that Congress is going too fast in providing medical research funds which are administered by the National Institutes of Health. He warned of a danger that the quality of research projects might be lowered and that manpower and other resources might be diverted from "equally vital teaching and medical practice."

He directed that every project approved must be "of such great promise that its deferment would be likely to delay progress in medical discovery."

Secretary Flemming said that the President's criteria would be followed conscientiously. But the secretary gave assurance that the restrictions would not be so rigid as to hamper research by denying funds for worthwhile projects.

One of the most important and surprising developments during this session of Congress was the political power shown by Mr. Eisenhower, a lame-duck Republican president, in generally calling the shots on legislation although Democrats controlled the House and Senate with substantial majorities.

In his fight against "big spending" measures sponsored by Democrats, the President effectively used his veto power to get the bills more to his liking. The Democrats were unable to muster the votes to override vetoes of two housing bills.

A third compromise housing bill retained three provisions of interest to the medical profession. One would provide Federal Housing Administration loan guarantees for building proprietary nursing homes. A second would provide FHA loan guarantees and direct loans for housing for elderly persons. The third would authorize loans for construction of housing for interns and nurses.

Live polio virus vaccine may be licensed for public use within a year or two. Dr. Leroy E. Burney, surgeon general of the Public Health Service, said: "If energetic efforts are continued to find answers to the remaining technical questions concerning safety, effectiveness and manufacturing procedures, one or more of the three vaccines now being proposed may be under production within one to two years."

Primary responsibility for radiation health safety has been transferred from the Atomic Energy Commission to the Department of Health, Education

*concluded on page 691*

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Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.<sup>1-10</sup> Studies performed in conjunction with gastrectomy<sup>4, 5</sup> and gastroscopy<sup>2</sup> have shown insoluble aspirin particles firmly adherent to

the gastric mucosa and imbedded between rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.<sup>2, 4, 5</sup> This is reported to be particularly true in patients with peptic ulcer.<sup>4</sup>

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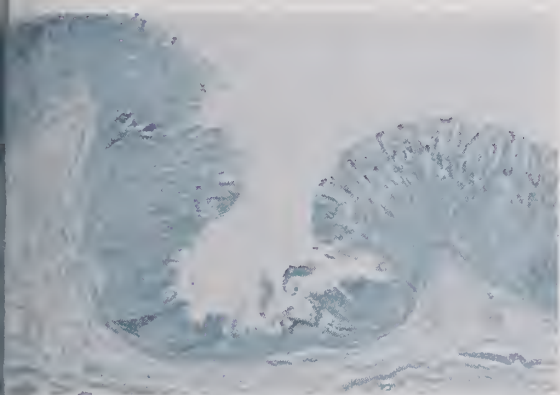


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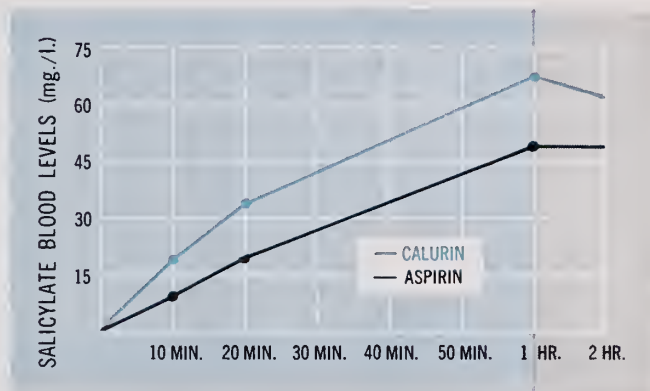


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**Aspirin-induced ulceration** — section through lesion in gastrectomy specimen. An aspirin particle was firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after absorption in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.<sup>11</sup>

**CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:**

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- 2 Produces high salicylate blood levels rapidly for prompt analgesic, antipyretic, anti-arthritis effect.
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- 4 Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

Each tablet of Calurin is equivalent to 300 mg. (5 gr.) acetylsalicylic acid. For relief of pain and fever in adults, the usual dose of Calurin is 1 to 3 tablets every 4 hours as needed; in arthritic states, 2 or 3 tablets 3 or 4 times

daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

**REFERENCES:** 1. Waterson, A. P.: Aspirin and gastric haemorrhage, *Brit. M. J.* 2:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic study of the effect of aspirin and certain other substances on the stomach, *Lancet* 2:1222, 1938. 3. Editorial Comments: The effect of acetylsalicylic acid (aspirin) on the gastric mucosa, *Canad. M. A. J.* 80:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, *Brit. M. J.* 2:7, 1955. 5. A., and Cossar, I. A.: Aspirin and gastric haemorrhage, *Lancet* 1:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, *Gastroenterology* 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, *New Eng. J. M.* 258:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, *New Eng. J. M.* 258:219, 1958. 10. Editorial: Aspirin plain and buffered, *Brit. M. J.* 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium acetylsalicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

\*TRADEMARK

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## BOOK REVIEWS

*A TEXTBOOK OF CLINICAL NEUROLOGY.* With an Introduction to the History of Neurology by Israel S. Wechsler, M.D. 8th ed. W. B. Saunders Co., Phil., 1958. \$11.00

This is the eighth edition of the well-known textbook of clinical neurology. The arrangement of subject material remains unchanged and, unfortunately, the recent advances in neurology are not well reflected.

The subject matter is divided into five sections with the traditional opening chapter on method of examination. This is followed by sections on *The Spinal Cord*, *The Peripheral Nerves*, and *The Brain*. The final section deals with *The Neuroses* and as in previous editions there is a concluding historical review of the *History of Neurology*. This organization of subject matter tends to obscure the addition of new information and imposes a rather forced relation upon several disease entities. Thus the metabolic encephalopathy of Wernicke is found in the discussion of the encephalitides while the myeloneuropathy of Charcot-Marie Tooth's disease is sandwiched between expositions of the *Progressive Muscular Dystrophies* and *Myotonia Congenita*.

The recent advances in neurochemistry and neuropharmacology are not well developed. The extensive studies in the past ten years of copper, amino acid, and protein metabolism in Wilson's disease are summarized in the statement, "Recent researches point to copper intoxication and metabolic disturbances." The new classifications of demyelinating diseases and the leuco dystrophies are not discussed, neither are the metabolic disturbances affecting muscle, peripheral nerve, cerebellum and cerebrum associated with various extra-neural neoplasms. Polymyositis is only briefly mentioned in the differential diagnosis of multiple neuritis. The sections dealing with cerebral vascular disease have been slightly expanded with brief reference to anticoagulation. Some of the techniques of electrical diagnosis are briefly described; there is no discussion of neuro-radiology.

The style has a distinct personal flavor, and the book retains its individual character reflecting the author's opinions and long clinical experience.

JOHN O. STROM, M.D.

*TEXTBOOK OF PEDIATRICS.* Edited by Waldo E. Nelson, M.D. W. B. Saunders Co., Phil., 1959. 7th ed. \$16.50

The seventh and latest edition of Nelson's *TEXTBOOK OF PEDIATRICS* is strong reason why most pediatricians consider it to be the "standard" pediatric textbook. Most textbooks, even in revision, are a few years behind the times. However, with few minor exceptions, this latest edition brings one up to date in almost every pediatric specialty.

Appropriately, some sections have been deleted or shortened, and new chapters on vital pediatric subjects have been added.

There is a great deal of emphasis on mental and emotional development as they relate to the total growth of the child, and the excellent section on accident prevention and treatment emphasizes the changing pediatric problems.

Pediatric neurology and psychiatry has had a revision, and the section on the physician and the child with a handicap succinctly presents a philosophy that every doctor who deals with children should constantly keep in mind. There are up-to-the-minute sections on the understanding and care of emotional problems.

For the more medically oriented pediatrician, there are completely rewritten chapters on clinical appraisal of infant and children, the newborn infant, parenteral fluid and therapy, drug therapy, and anesthesia. Mycotic infections, tropical diseases, and the more unusual pediatric disorders all receive a face wash.

Illustrations and charts are excellent and profusely scattered throughout the book.

This textbook is a must on the bookshelf of practitioners with children.

ERIC DENHOFF, M.D.

---

**Providence Medical Association Meeting**

**Monday, November 2, 1959**

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---

## THE WASHINGTON SCENE

*concluded from page 687*

and Welfare.

Such a shift in responsibility was called for in legislation pending in Congress but President Eisenhower ordered the transfer without Congressional action.

The President directed HEW to "intensify its radiological health efforts and have primary responsibility . . . for the collation, analysis and interpretation of data on environmental radiation levels such as natural background, radiography, medical and industrial uses of isotopes and X rays and fallout."

HEW Secretary Flemming also was named chairman of a cabinet-level Federal Radiation Council.

Officers in charge of the Medicare program for military dependents were optimistic that certain medical benefits dropped for economy reasons in October, 1958, will be restored next January 1. But the professional director of the program, Col. Norman E. Peatfield, said that the Medicare permit system will be retained.

## STATE'S REHABILITATION PROGRAM FOR CHRONIC ILLNESS AND DISABILITY

*concluded from page 677*

This evidence may be a report from his attending physician or from a hospital, institution, public or private agency where he has been treated for his disabling condition.

It is the function of the Old-Age and Survivors Insurance Disability Unit to process these claims and to determine eligibility or ineligibility for benefits.

This unit has been in operation since August of 1955 and at the present is processing an average of 225 claims each month.

## COLLEGE OF SURGEONS INDUCTS

Rhode Islanders inducted as new Fellows of the American College of Surgeons at the Clinical Congress held at Atlantic City early in October were the following:

Capt. Halvdan G. K. Faaland, of Newport; Dr. Herbert G. Rock of Warwick; and from Providence, Drs. Francis P. Catanzaro, William P. Corvese, Raymond N. MacAndrew, Richard P. Sexton, and Lester L. Vargas.

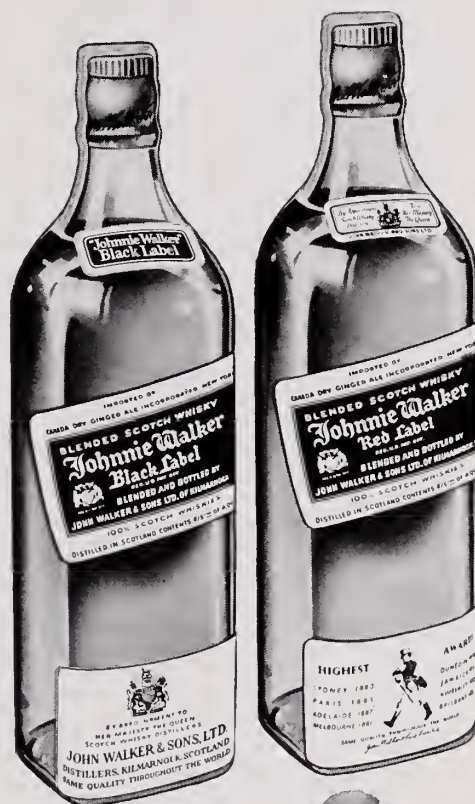
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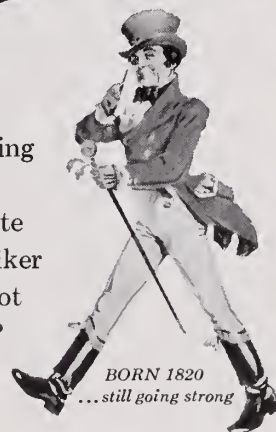
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### OKLAHOMA CITY, OKLAHOMA

Fri., Oct. 2, 1959, The Skirvin Hotel

### BIRMINGHAM, ALABAMA

Sun., Oct. 11, 1959, The Dinkler-Tutwiler Hotel

### TACOMA, WASHINGTON

Wed., Oct. 14, 1959, The Hotel Winthrop

### TRAVERSE CITY, MICHIGAN

Fri., Oct. 23, 1959, The Park Place Hotel

### LUBBOCK, TEXAS

Sat., Oct. 31, 1959, The Lubbock Country Club

### ST. CHARLES, ILLINOIS

Wed., Nov. 4, 1959, The St. Charles Country Club

### DALLAS, TEXAS

Fri., Nov. 6, 1959, The Hilton Hotel

### WICHITA, KANSAS

Sat., Nov. 7, 1959, The Hotel Broadview

### SCHENECTADY, NEW YORK

Thurs., Nov. 12, 1959, The Mohawk Golf Club

### CORPUS CHRISTI, TEXAS

Fri., Nov. 13, 1959, The Robert Driscoll Hotel

### RIVERSIDE, CALIFORNIA

Sun., Nov. 15, 1959, The Mission Inn

### SANTA BARBARA, CALIFORNIA

Wed., Nov. 18, 1959, The Santa Barbara Biltmore

### MOLINE, ILLINOIS

Wed., Dec. 2, 1959, The LeClaire Hotel

## 1960 Symposia (incomplete schedule)

### DENVER, COLORADO

Sun., Jan. 10, 1960, The Cosmopolitan Hotel

### AUSTIN, TEXAS

Fri., Jan. 15, 1960, The Commodore Perry

### POCATELLO, IDAHO

Sat., April 2, 1960, The Bannock Hotel

### MOORHEAD, MINNESOTA

Sat., April 9, 1960, The Frederick Martin Hotel

### SALT LAKE CITY, UTAH

Fri., April 22, 1960, Hotel Utah

### ST. LOUIS, MISSOURI

Sun., May 1, 1960, Chase-Park Plaza

### SANTA ROSA, CALIFORNIA

Fri., Sept. 16, 1960, The Flamingo Hotel

### GREAT FALLS, MONTANA

Sat., Oct. 22, 1960, The Rainbow Hotel

### CHARLESTON, WEST VIRGINIA

Sun., Oct. 30, 1960, The Daniel Boone Hotel

In cooperation with medical organizations throughout the United States, Lederle continues to offer aid to post-graduate medical education through its Symposium program. Upon completion of the schedule above the number of Symposia presented will exceed 200 since the first meeting, sponsored by the Knoxville (Tenn.) Academy of Medicine eight years ago. Each meeting presents prominent authorities discussing important advances in clinical medicine and surgery. Activities are also planned for physicians' wives.

# DEPRESSION: TREATMENT OF OFFICE PATIENTS WITH PHENELZINE

*concluded from page 671*

Serotonin by Iproniazid. Fed. Proc., 15:409, 1956

<sup>3</sup>Brodie, B. B., and Shore, P. A.: Mechanism of Action of Psychotropic Drugs. In Kline, N. S. (ed.) Psychopharmacology Frontiers, p. 413, Little, Brown and Company, Boston, 1959

<sup>4</sup>Loomer, H. P.; Saunders, J. A., and Kline, N. S.: A Clinical and Pharmacodynamic Evaluation of Iproniazid as a Psychic Energizer. In Cleghorn, R. A. (ed.) Research in Affects, Psychiatric Research Report 8 of the American Psychiatric Asso., Washington, D.C., pp. 129-141, Dec. 1957

<sup>5</sup>Chessin, M.; Dubnick, B.; Leeson, G., and Scott, C. C.: Biochemical and Pharmacological Studies of beta-phenylethylhydrazine and Selected Related Compounds. Annals of the New York Academy of Sciences. In press

<sup>6</sup>Leeson, G. A.; Dubnick, B., and Scott, C. C.: Effect of Forms of Vitamin B<sub>6</sub> on Acute Toxicity of beta-phenylethylhydrazine. Fed. Proc., 18:(part I)414, 1959

<sup>7</sup>Sainz, A.; Bigelow, N., and Barwise, C.: Rapid Screening of Phrenopraxic Drugs. Psychiatric Quarterly, 32:273, 1959

<sup>8</sup>Sainz, A.: The Phrenopraxic Activity of a Nonnoxious Antidepressant. Presented at Conference on Amine Oxidase Inhibitors. The New York Academy of Sciences, Nov. 20-22, 1959. In press

<sup>9</sup>Saunders, J. C.; Roukema, R. W.; Kline, N. S., and Bailey, S. d'A.: Clinical Results with Phenelzine. Am. J. Psych., 116:71, 1959

<sup>10</sup>Thal, N.: Cumulative Index of Antidepressant Medications. Dis. Nerv. Sys., 20:197, 1959

<sup>11</sup>Furst, W.: Therapeutic Re-Orientation in Some Depressive States: Clinical Evaluation of a New Monoamine Oxidase Inhibitor (W1544A). J. Am. Psych. In press

<sup>12</sup>Arnow, L. E.: Phenelzine: A New Drug Effective Against Mental Depression. Geriatrics. In press

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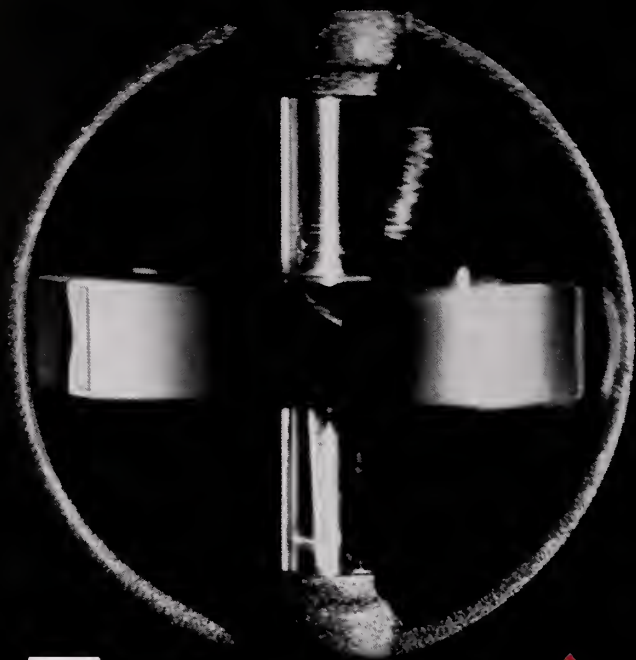
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**References:** 1. Feinberg, S.M., Feinberg, A.R., and Fisherman, E.W.: *J.A.M.A.* 167:58 (May 3) 1958. 2. Epstein, J.I. and Sherwood, H.: *Connecticut Med.* 22:322 (Dec.) 1958. 3. Friedlaender, S. and Friedlaender, A.S.: *Antibiotic Med. & Clin. Ther.* 5:315 (May) 1958. 4. Segal, M.S. and Duvenci, J.: *Bull. Tufts North East M. Center* 4:71 (April-June) 1958. 5. Segal, M.S.: Report to the A.M.A. Council on Drugs, *J.A.M.A.* 169:1063 (March 7) 1958. 6. Sherwood, H. and Cooke, R.A.: *J. Allergy* 28:97 (Mar.) 1958. 7. Duke, C.J. and Oviedo, R.: *Antibiotic Med. & Clin. Ther.* 5:710 (Dec.) 1958. 8. McGavack, T.H.: *Clin. Med.* (June) 1958. 9. Freyberg, R.H.; Bernstau, C.A., and Hellman, L.: *Arthritis and Rheumatism* 1:215 (June) 1958. 10. Hartung, E.F.: *J.A.M.A.* 167:973 (June 21) 1958. 11. Hartung, E.F.: *J. Florida Acad. Gen. Pract.* 8:18, 1958. 12. Zuckner, J.; Ramsey, R.H.; Caciolo, C., and Gantner, G.E.: *Ann. Rheum. Dis.* 17:598 (Dec.) 1958. 13. Appel, B.; Tye, M.J., and Leibsohn, E.: *Antibiotic Med. & Clin. Ther.* 5:716 (Dec.) 1958. 14. Kalz, F.: *Canad. M.A.J.* 79:400 (Sept.) 1958. 15. Mullins, J.F., and Wilson, C.J.: *Texas State J. Med.* 54:648 (Sept.) 1958. 16. Shelley, W.B.; Harun, J.S., and Pillsbury, D.M.: *J.A.M.A.* 167:959 (June 21) 1958. 17. DuBois, E.F.: *J.A.M.A.* 167:1590 (July 26) 1958. 18. McGavack, T.H.; Kao, K.T.; Leake, D.A.; Bauer, H.G., and Berger, H.E.: *Am. J. Med. Sc.* 236:720 (Dec.) 1958. 19. Council on Drugs: *J.A.M.A.* 169:237 (Jan. 17) 1959. 20. Rein, C.R.; Fleischmajer, R., and Rosenthal, A.R.: *J.A.M.A.* 165:1821 (Dec. 7) 1957.

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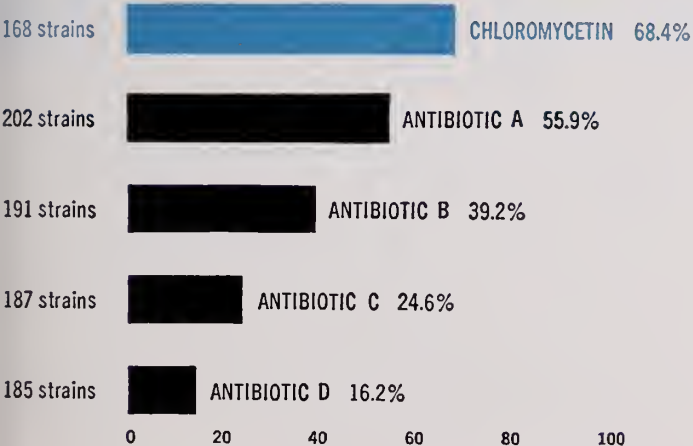
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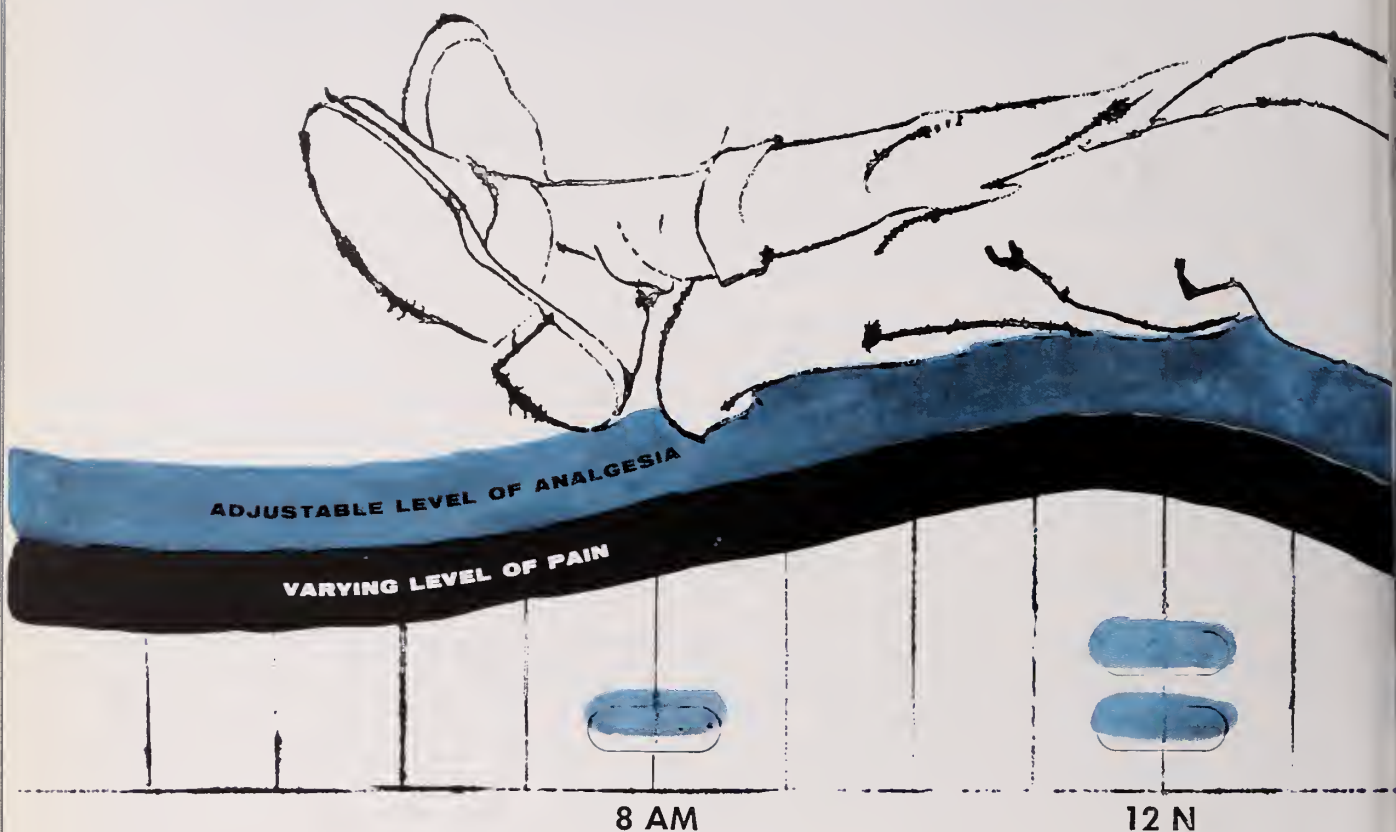
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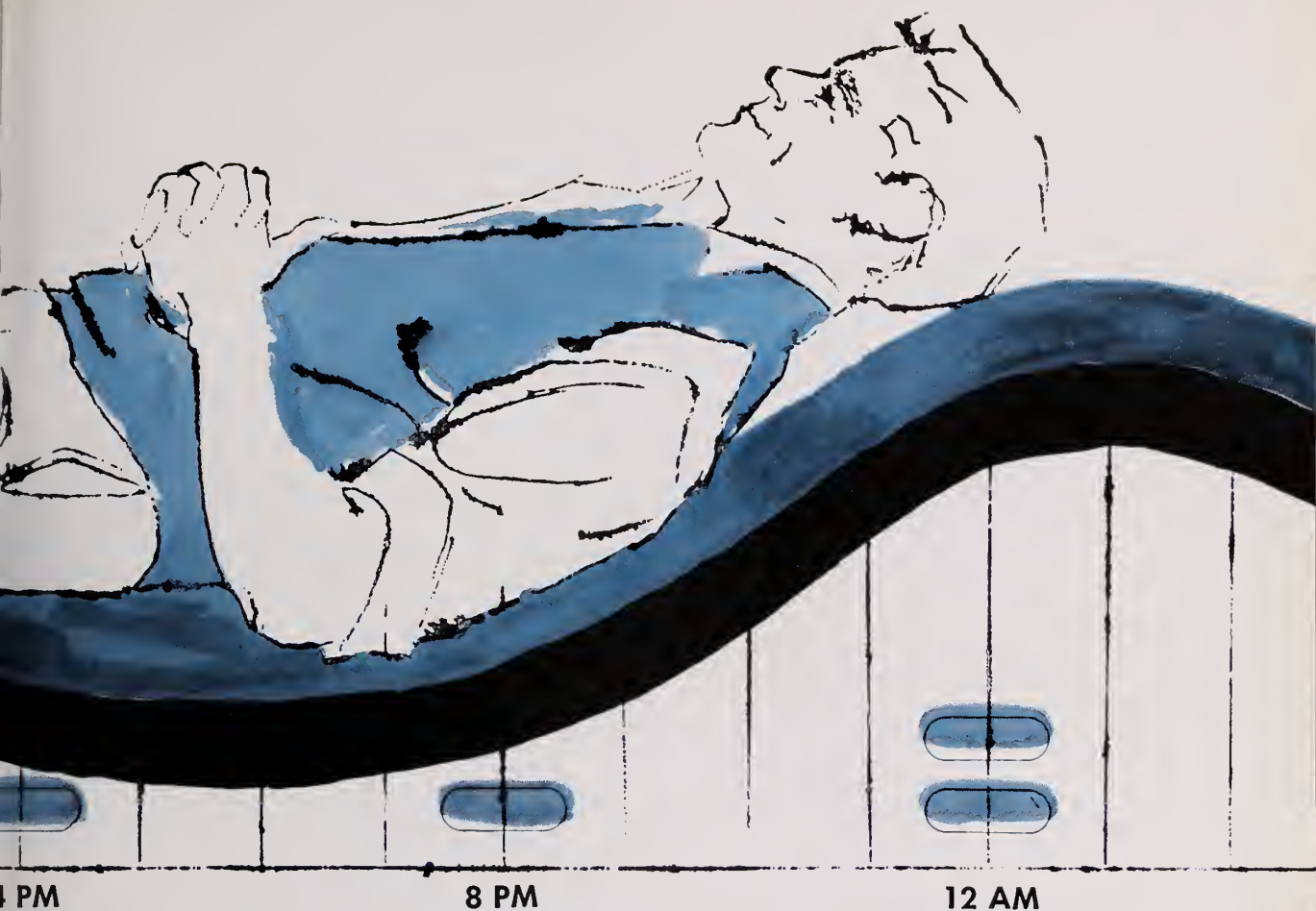


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DOSAGE: One or two capsules as required.

If one . . . or all . . . needs nutritional support . . .



they  
deserve

# GEVRAL<sup>®</sup> capsules—14 VITAMINS AND 11 MINERALS

Vitamin-Mineral Supplement Lederle

For Complete Formula see PDR (Physicians' Desk Reference), page 689

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York





**2 NEW FORMS OF CORICIDIN**

**relieve sinusitis  
colds • allergic rhinitis**



decongestant • antihistaminic  
analgesic • antipyretic

**ORAL  
CORICIDIN "D"  
Decongestant Tablets**

combine dependable  
CORICIDIN benefits with specific  
action of phenylephrine  
to provide rapid prolonged relief  
of congested respiratory passages

Each CORICIDIN "D" tablet contains 2 mg. CHLOR-TRIMETON® Maleate, 0.23 Gm. aspirin, 0.16 Gm. phenacetin,  
30 mg. caffeine and 10 mg. phenylephrine boxes of 12 tablets

Each cc. of CORICIDIN® Nasal Mist contains 3 mg. CHLOR-TRIMETON Gluconate, 5 mg. phenylephrine  
hydrochloride and 0.05 mg. gramicidin squeeze-bottles of 20 cc.

**TOPICAL | decongestant •  
CORICIDIN antihistaminic • antibiotic  
Nasal Mist**

offers prompt topical symptomatic  
relief of congested nasal mucosa and  
controls excessive nasal drainage  
without rebound effects

*Schering*

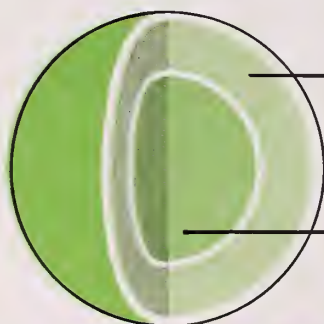
**SCHERING CORPORATION • BLOOMFIELD, NEW JERSEY**



## the complaint: "nervous indigestion"

**the diagnosis:** any one of several nonspecific gastrointestinal disorders requiring relief of symptoms by sedative-antispasmodic action with concomitant digestive enzyme therapy.

**the prescription:** a new formulation, incorporating in a single tablet the actions of Donnatal and Entozyme. **the dosage:** two tablets three times a day, or as indicated.



### *the formula: in the gastric-soluble outer layer:*

Hyoscyamine sulfate .....	0.0518 mg.
Atropine sulfate .....	0.0097 mg.
Hyoscine hydrobromide .....	0.0033 mg.
Phenobarbital ( $\frac{1}{8}$ gr.) .....	8.1 mg.
Pepsin, N.F. ....	150 mg.

### *in the enteric-coated core:*

Pancreatin, N.F. ....	300 mg.
Bile salts .....	150 mg.

# DONNAZYME<sup>TM</sup>



A. H. ROBINS COMPANY, INCORPORATED • RICHMOND 20, VIRGINIA



*For the first time*

## CONVENIENCE and ECONOMY

*for that all-important first dose  
of broad-spectrum antibiotic therapy*

*New*

**TERRAMYCIN<sup>®</sup>**

brand of oxytetracycline

## INTRAMUSCULAR SOLUTION

Initiation of therapy in *minutes after diagnosis*  
with new, ready-to-inject Terramycin Intra-  
muscular Solution provides maximum, sustained  
absorption of potent broad-spectrum activity.

*...and for continued, compatible,  
coordinated therapy*

## COSA-TERRAMYCIN<sup>®</sup>

oxytetracycline with glucosamine

Continuation with oral Cosa-Terramycin  
every six hours will provide highly effective  
antibacterial serum and tissue levels for  
prompt infection control.

The unsurpassed record of clinical effectiveness  
and safety established for Terramycin  
is your guide to successful antibiotic therapy.

*Supply:*

*Terramycin Intramuscular Solution\**

100 mg./2 cc. ampules

250 mg./2 cc. ampules

*Cosa-Terramycin Capsules*

125 mg. and 250 mg.

*Cosa-Terramycin is also available as:*

*Cosa-Terramycin Oral Suspension* — peach flavored,  
125 mg./5 cc., 2 oz. bottle

*Cosa-Terramycin Pediatric Drops* — peach flavored,  
5 mg./drop (100 mg./cc.), 10 cc. bottle  
with plastic calibrated dropper

Complete information on Terramycin Intramuscular  
Solution and Cosa-Terramycin oral forms is  
available through your Pfizer Representative or the  
Medical Department, Pfizer Laboratories.

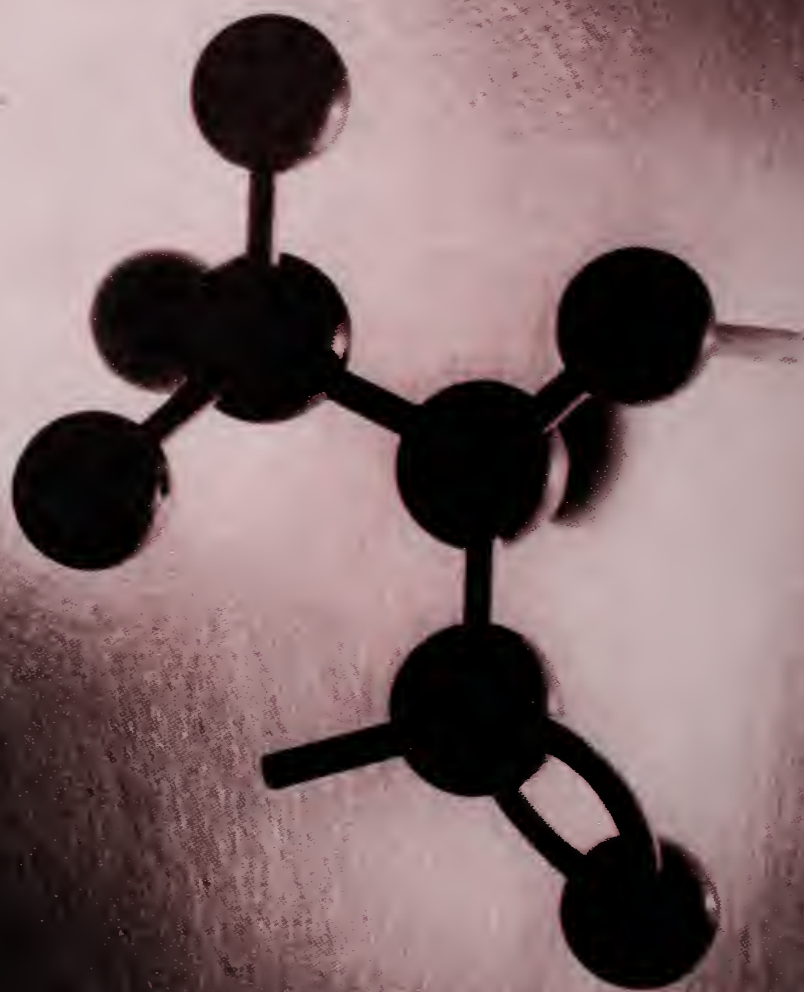
\*Contains 2% Xylocaine<sup>®</sup> (lidocaine), trademark  
of Astra Pharmaceutical Products, Inc.

**Pfizer**

*Science for the world's well-being™*

PFIZER LABORATORIES, Division, Chas. Pfizer & Co., Inc.,  
Brooklyn 6, N. Y.



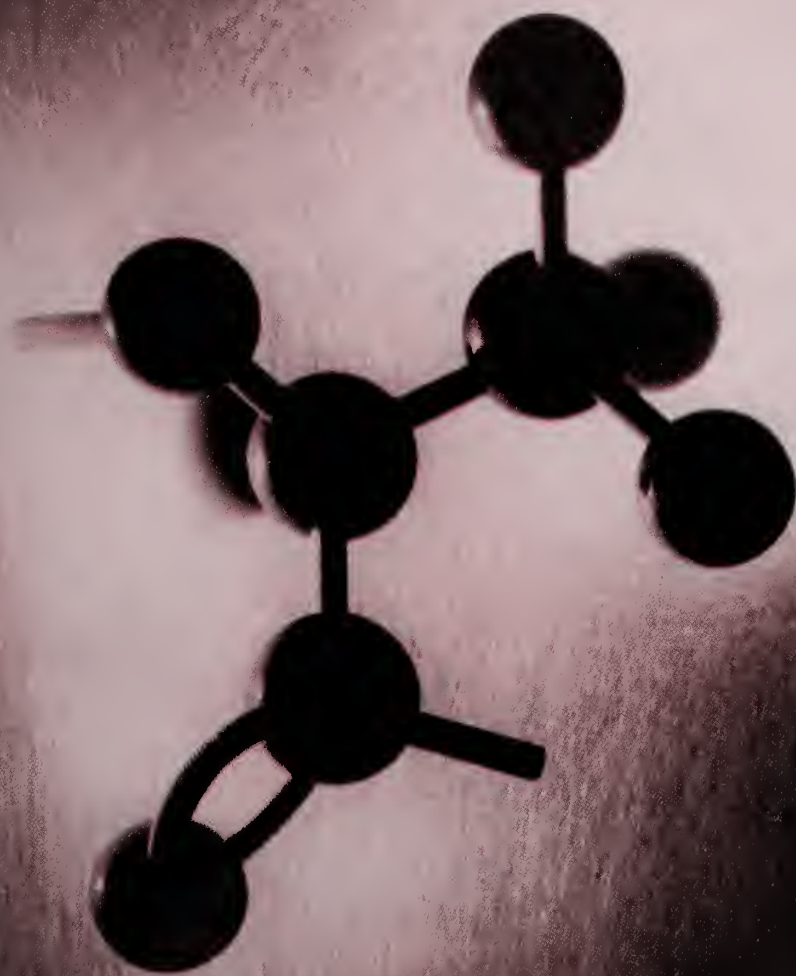


*IS MOLECULAR ASYMMETRY REFLECTED IN  
UNUSUAL DIFFERENTIALS BETWEEN  
IN VITRO M.I.C. AND IN VIVO  $CD_{50}$  RESPONSES?*

*This question will be answered soon...*



Bristol Laboratories Inc., Syracuse, New York



IN VITRO M.I.C. AND IN VIVO CD<sub>50</sub> RESPONSES?  
 UNUSUAL DIFFERENTIALS BETWEEN  
 IS MOLECULAR ASYMMETRY REFLECTED IN

This question will be answered soon...





*Aylsworth Travel Service, Inc.*  
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Dear Doctor—

Do you know that Aylsworth Travel Service receives its commissions from the hotels and carriers — not from you?

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Sincerely —  
Richard A. Jenks  
President

**LONG-TERM DISABILITY  
INSURANCE WHICH ONLY  
YOU CAN CANCEL  
BEFORE AGE 70\***

*is one of the necessary  
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**CERTIFIED  
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PROGRAM**  
for the*

Physician who wants to KNOW he's secure!  
Programs certified by Mr. R. A. Derosier and  
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\*provided you pay the proper premium when due, and do not retire.

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details  
write or  
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TODAY!

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New England's Largest Exclusive Furrier  
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anything  
darling...  
as long as  
it's a  
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Our Mink collection of lovely scarfs, stoles, jackets and coats is priced from \$99. to \$6950.

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MEN!**

Your selection held and gift wrapped for Christmas. Any purchase cheerfully exchanged within one week after Christmas.

Trained gift counsellors will assist you.

Charge or Budget  
Terms Available



**JUST ONE TABLET DAILY**

provides therapeutic levels... for 24 hours...  
with low incidence of sensitivity reactions...  
**WHENEVER SULFAS ARE INDICATED**®

**KYNEX**

Sulfamethoxypyridazine Lederle

0.5 Gm. TABLETS/NEW ACETYL PEDIATRIC SUSPENSION

LEDERLE LABORATORIES, a Division of  
AMERICAN CYANAMID COMPANY, Pearl River, New York

*Lederle*





**JUST ONE TABLET DAILY**

provides therapeutic levels . . . for 24 hours . . .  
with low incidence of sensitivity reactions . . .  
WHENEVER SULFAS ARE INDICATED

**KYNEX**

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0.5 Gm. TABLETS/NEW ACETYL PEDIATRIC SUSPENSION

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AMERICAN CYANAMID COMPANY, Pearl River, New York

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**LINGUA FRANCA\***



\*TRANSLATION:

Frank's hanging  
around for some

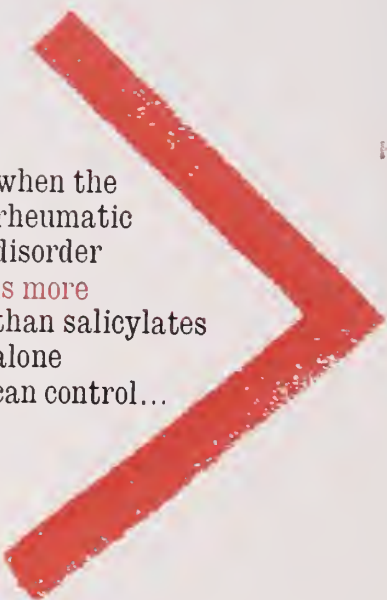
**WARWICK  
CLUB  
GINGER ALE**

*It sings in the glass*



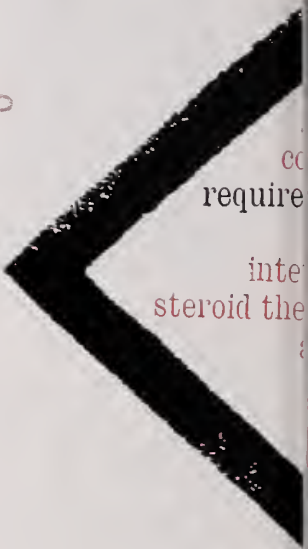
**Wherever you go  
forget your telephone  
calls. We'll take them  
for you, day or night.**

**MEDICAL BUREAU**  
of the  
**Providence Medical Association**



when the  
rheumatic  
disorder  
is more  
than salicylates  
alone  
can control...

MORE  
HIGHLY INDIVIDUALIZED  
THERAPY  
FOR THE  
RHEUMATIC  
"IN-BETWEEN"



cc  
require  
inte  
steroid the  
s

# Aristo

## wider latitude in adjusting dosage

ARISTOGESIC is particularly effective for relief of chronic — but less severe — pain of rheumatic origin. ARISTOGESIC combines the anti-inflammatory effects of ARISTOCORT® Triamcinolone with the analgesic action of salicylamide, a highly potent salicylate. Dosage requirements for ARISTOGESIC are substantially lower than generally required for each agent alone. The exceptionally wide latitude of dosage adjustment with ARISTOGESIC permits well-tolerated therapy for long periods of time with fewer side effects.

*Indications:* Mild cases of rheumatoid arthritis, tenosynovitis, synovitis, bursitis, mild spondylitis, myositis, fibrositis, neuritis, and certain muscular strains.

*Dosage:* Average initial dosage: 2 capsules 3 or 4 times daily. Maintenance dosage to be adjusted according to response.

*Precautions:* All precautions and contraindications traditional to corticosteroid therapy should be observed. The amount of drug used should be carefully adjusted to the lowest dosage which will suppress symptoms. Discontinuance of therapy must be carried out gradually after patients have been on steroids for prolonged periods.

Each ARISTOGESIC Capsule contains:

ARISTOCORT® Triamcinolone.....	0.5 mg.
Salicylamide .....	325 mg.
Dried Aluminum Hydroxide Gel.....	75 mg.
Ascorbic Acid.....	20 mg.

*Supply:* Bottles of 100 and 1,000.

  
Steroid-Analgesic Compound LEDERLE



RL LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



# AN AMES CLINIQUICK<sup>TM</sup>

CLINICAL BRIEFS FROM MODERN PRACTICE

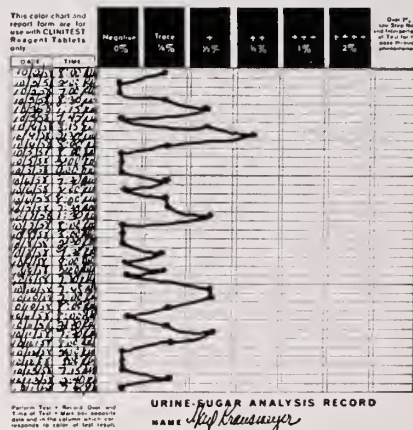
## *What differentiates "renal diabetes" (renal glycosuria) from diabetes mellitus?*

Blood sugar levels. In renal glycosuria they are normal; in untreated diabetes, fasting blood sugars are usually 130 mg.% or over and postprandial levels 170 mg.%, or more.

Source: Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: The Treatment of Diabetes Mellitus, ed. 9, Philadelphia, Lea & Febiger, 1952, pp. 701-702.

## A "URINE-SUGAR PROFILE" FOR CLOSER CONTROL

The new CLINITEST Urine-Sugar Analysis Set contains an improved Analysis Record form that enables even closer control of the *moderate* and the *severe* diabetic. Daily urine-sugar readings may be connected to produce a graph—a day-to-day "profile" that reveals at a glance individual trends and degree of control.





# NIAMID\*

## reduces pain in angina pectoris

**NIAMID**, in intensive clinical tests, has proved to have a high degree of safety and to be a valuable adjunct in the management of the anginal syndrome. NIAMID produces striking symptomatic improvement in angina patients...

- reduces frequency of anginal episodes
- diminishes severity of attacks
- decreases nitroglycerin requirements
- renews sense of well-being

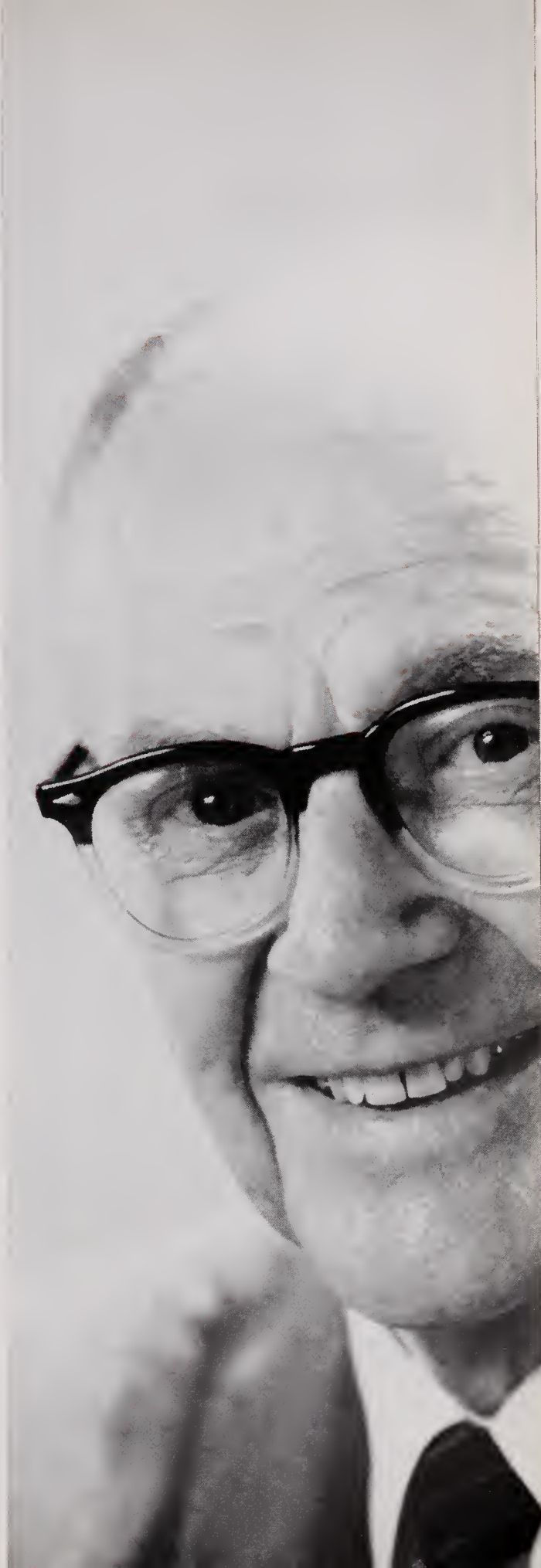
*Note:* Because of dramatic relief of symptoms and increased sense of well-being in anginal cases, it is advisable to caution the patient against overexertion.

**DOSAGE:** Start with 75 mg. of NIAMID daily in single or divided doses. After 2 weeks or more, adjust the dosage, depending upon patient response, in steps of one or one-half 25 mg. tablet. Once improvement is seen, gradually reduce dosage to the maintenance level. Many patients respond to NIAMID within a few days, others within 7 to 14 days. NIAMID is available as 25 mg. (pink) and 100 mg. (orange) scored tablets.

*A Professional Information Booklet giving detailed information on NIAMID is available on request from the Medical Department, Pfizer Laboratories, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.*

\*Trademark for nialamide

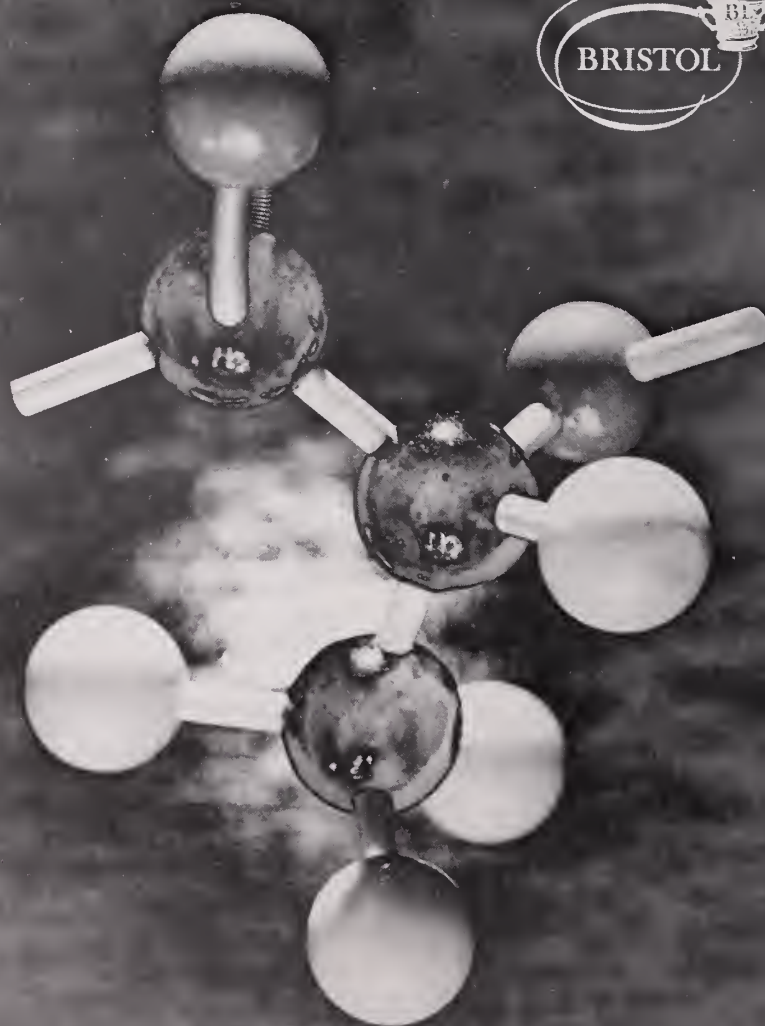
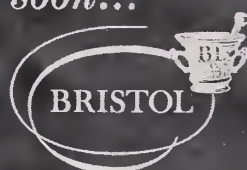
**Pfizer** Science for the world's well-being™





*IS MOLECULAR ASYMMETRY  
REFLECTED IN CHANGES  
IN ANTIBACTERIAL ACTIVITY?*

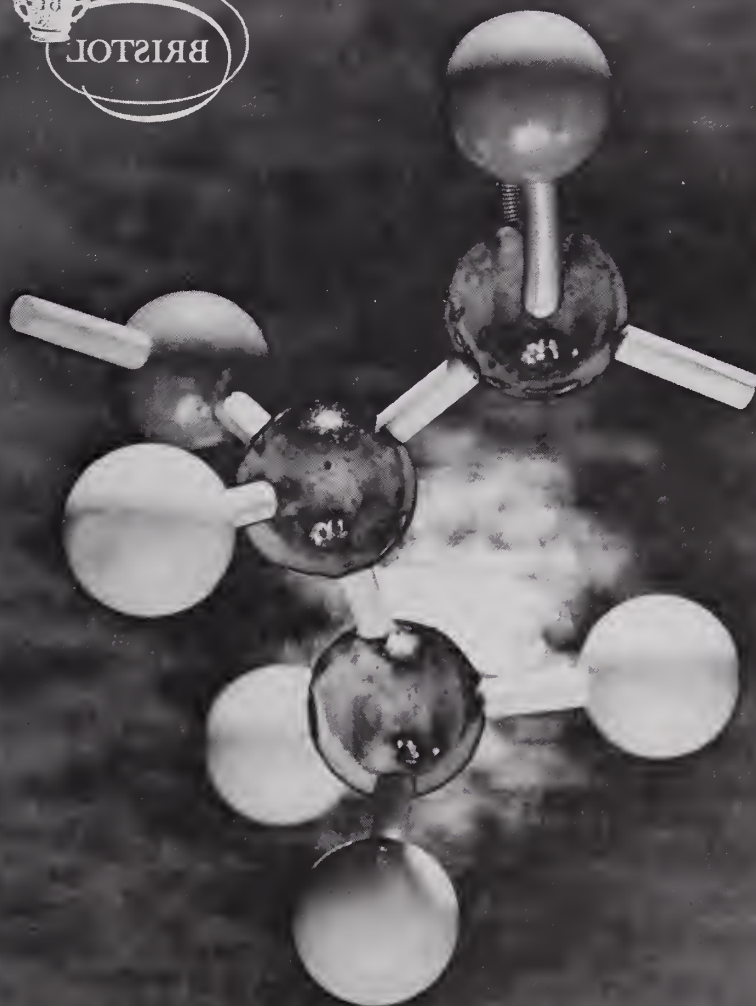
*This question will be answered soon...*





IN ANTIBACTERIAL ACTIVITY?  
REFLECTED IN CHANGES  
IS MOLECULAR ASYMMETRY

This question will be answered soon...



NOW... SAFER, EFFECTIVE TRANQUILIZER THERAPY

tranquilization

anti-emetic

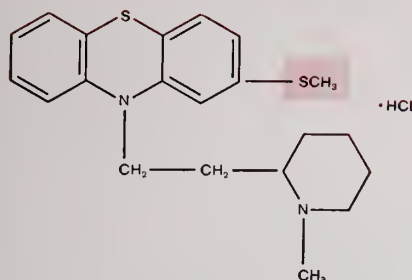
greater specificity  
of tranquilizing action  
—divorced from such  
"diffuse" effects as  
anti-emetic action  
—explains why

 **Mellaril**<sup>®</sup>  
THIORIDAZINE HCl

is virtually free of such toxic effects as • jaundice • Parkinsonism • blood dyscrasia

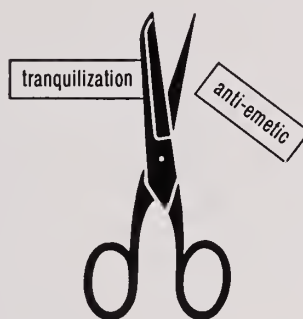
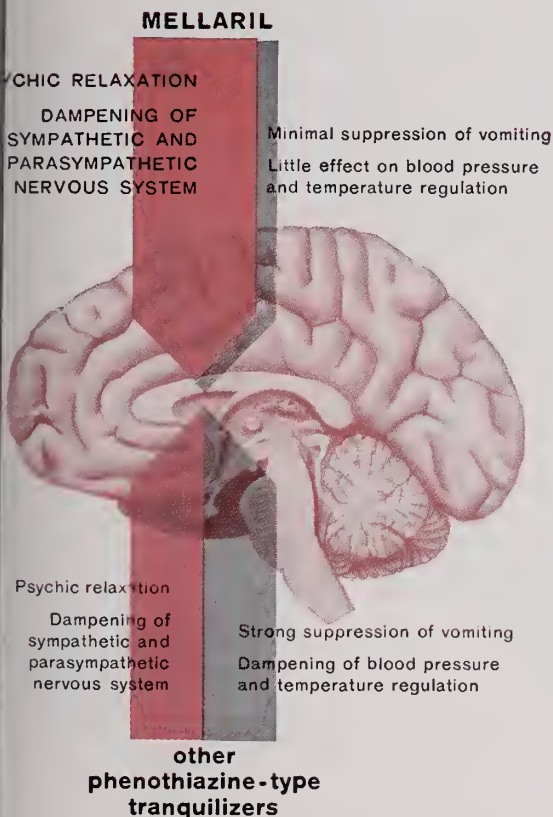
"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines. ... This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."\*

# new advance in tranquilization: greater specificity of tranquilizing action results in fewer side effects



*The presence of a thiomethyl radical (S-CH<sub>3</sub>) is unique in Mellaril and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:*

- 1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.



- 2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.
- 3 A notable absence of extrapyramidal stimulation.
- 4 Lack of impairment of patient's normal drive and energy.
- 5 Virtual freedom from such toxic effects as jaundice, photosensitivity, skin eruptions, blood forming disorders.

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
<b>ADULTS:</b> Mental and Emotional Disturbances: MILD — where anxiety, apprehension and tension are present MODERATE — where agitation exists in psychoneuroses, alcoholism, intractable pain, senility, etc. SEVERE — in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.: Ambulatory Hospitalized	10 mg. t.i.d.	20-60 mg.
	25 mg. t.i.d.	50-200 mg.
	100 mg. t.i.d.	200-400 mg.
	100 mg. t.i.d.	200-800 mg.
<b>CHILDREN:</b> BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

**MELLARIL** Tablets, 10 mg., 25 mg., 100 mg.

Stefeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959





*for  
the  
tense  
and  
nervous  
patient*



relief comes fast and comfortably

- does not produce autonomic side reactions
- does not impair mental efficiency, motor control, or normal behavior.

*Usual Dosage:* One or two 400 mg. tablets t.i.d.

*Supplied:* 400 mg. scored tablets, 200 mg. sugar-coated tablets or as MEPROTABS\*—400 mg. unmarked, coated tablets.

**Miltown<sup>®</sup>**

meprobamate (Wallace)



**WALLACE LABORATORIES / New Brunswick, N. J.**

CH-9470

Your difficult rheumatic patient...

*on the job again*

through effective relief and rehabilitation

For the patient who does not require steroids

**PABALATE®**

Reciprocally acting nonsteroid antirheumatics... more effective than salicylate alone.

In each enteric-coated tablet:

Sodium salicylate U.S.P. .... 0.3 Gm. (5 gr.)  
Sodium  
para-aminobenzoate .... 0.3 Gm. (5 gr.)  
Ascorbic acid ..... 50.0 mg.

or for the patient  
who should avoid sodium

**PABALATE® - Sodium Free**

Pabalate, with sodium salts replaced by potassium salts.

In each enteric-coated tablet:

Potassium salicylate ..... 0.3 Gm. (5 gr.)  
Potassium  
para-aminobenzoate .... 0.3 Gm. (5 gr.)  
Ascorbic acid ..... 50.0 mg.

For the patient  
who requires steroids

**PABALATE®-HC**

(PABALATE WITH HYDROCORTISONE)

Comprehensive synergistic combination of steroid and nonsteroid antirheumatics... full hormone effects on low hormone dosage... satisfactory remission of rheumatic symptoms in 85% of patients tested.

In each enteric-coated tablet:

Hydrocortisone (alcohol) ..... 2.5 mg.  
Potassium salicylate ..... 0.3 Gm.  
Potassium para-aminobenzoate.. 0.3 Gm.  
Ascorbic acid ..... 50.0 mg.

**PABALATE®**  **PABALATE®-HC**

For steroid or non-steroid therapy: SAFE DEPENDABLE ECONOMICAL

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA • Ethical Pharmaceuticals of Merit since 1878

*relieve the tension—and control its G.I. sequelae*





# ...Pathibamate®

meprobamate with PATHILON® tridihexethyl chloride Lederle

*for relieving tension and curbing hypermotility  
and excessive secretion in G. I. disorders*

**PATHIBAMATE** combines two highly effective and well-tolerated therapeutic agents:

meprobamate (400 mg. or 200 mg.)—a tranquilizer and muscle-relaxant widely accepted for the effective management of tension and anxiety

**PATHILON** (25 mg.)—an anticholinergic long noted for producing prompt symptomatic relief through peripheral, atropine-like action, yet with few side effects

*now available...*

## **PATHIBAMATE-200 Tablets**

200 mg. meprobamate • 25 mg. PATHILON

*for more flexible control of G. I. trauma and tension  
smooth, sugar-coated, easy-to-swallow*

PATHIBAMATE-400 and PATHIBAMATE-200 are indicated for duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

**Supplied:** **PATHIBAMATE-400**—Each tablet (yellow, 1/2-scored) contains meprobamate, 400 mg.; PATHILON tridihexethyl chloride 25 mg.

**PATHIBAMATE-200**—Each tablet (yellow, coated) contains meprobamate, 200 mg.; PATHILON tridihexethyl chloride, 25 mg.

**Administration and Dosage:** **PATHIBAMATE-400**—1 tablet three times a day at mealtime and 2 tablets at bedtime.

**PATHIBAMATE-200**—1 or 2 tablets three times a day at mealtime and 2 tablets at bedtime.

Adjust dosage to patient response.

**Contraindications:** glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.



LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

# avoid the risk of insoluble, irritating aspirin particles

Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.<sup>1-10</sup> Studies performed in conjunction with gastrectomy<sup>4,5</sup> and gastroscopy<sup>2</sup> have shown insoluble aspirin particles firmly adherent to

the gastric mucosa and imbedded between rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.<sup>2,4,5</sup> This is reported to be particularly true in patients with peptic ulcer.<sup>4</sup>

**CALURIN is the freely soluble, stable calcium aspirin complex. Its high solubility forestalls gastric irritation or damage**



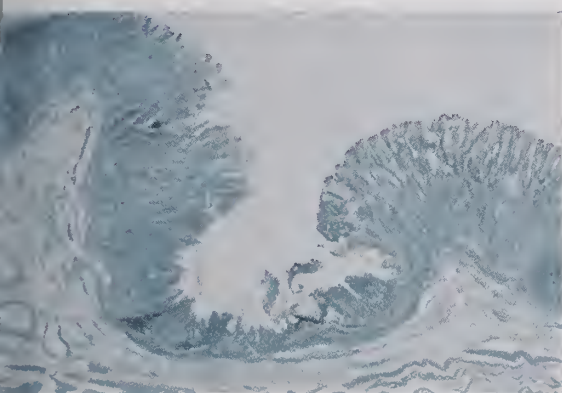
Regular aspirin crystals 24 hours after being mixed into water.



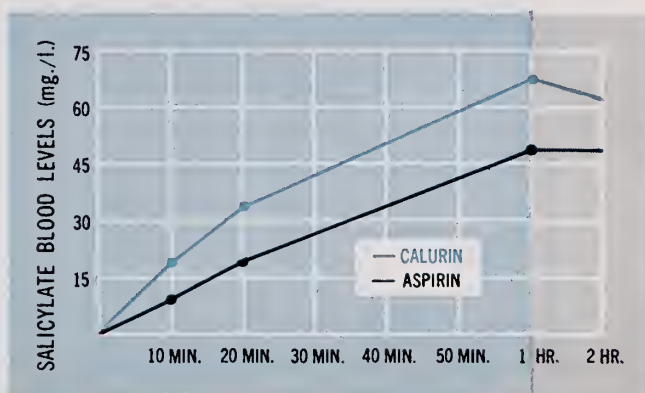
Calurin crystals in solution one minute after being mixed into water.

# CALURIN\*

TABLET SOLUBLE CALCIUM-ACETYSALICYLATE-CARBAMIDE



**Aspirin-induced ulceration** — section through lesion in gastrectomy specimen. An aspirin particle was firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after absorption in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.<sup>11</sup>

**CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:**

- 1 High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
- 2 Produces high salicylate blood levels rapidly for prompt analgesic, antipyretic, anti-arthritic effect.
- 3 Sodium-free — for safer long-term therapy.
- 4 Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

**Dosage:** Each tablet of Calurin is equivalent to 300 mg. (5 gr.) acetylsalicylic acid. For relief of pain and fever in adults, the usual dose of Calurin is 1 to 3 tablets every 4 hours as needed; in arthritic states, 2 or 3 tablets 3 or 4 times

daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

**REFERENCES:** 1. Waterson, A. P.: Aspirin and gastric haemorrhage, *Brit. M. J.* 2:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic observation of the effect of aspirin and certain other substances on the stomach, *Lancet* 2:1222, 1938. 3. Editorial Comments: The effect of acetylsalicylic acid (aspirin) on the gastric mucosa, *Canad. M. A. J.* 80:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, *Brit. M. J.* 2:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, *Lancet* 1:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, *Gastroenterology* 31:1, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, *New Eng. J. M.* 258:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, *New Eng. J. M.* 258:219, 1958. 10. Editorial: Aspirin plain and buffered, *Brit. M. J.* 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium acetylsalicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

\*TRADEMARK

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska





## Underweight Children Gain and Retain Weight with Nilevar®

One of the most convincing evidences of the anabolic activity of Nilevar, brand of norethandrolone, has been its ability to improve appetite and increase weight in poorly nourished, underweight children.

A highly important feature of the weight gain thus produced is that it is not ordinarily manifested by deposition of fat but as muscle tissue resulting from the protein anabolism induced by Nilevar.

**Anorexia and "Weight Lag" Study**—Brown, Libo and Nussbaum have reported\* consistent and definite increases in rate of weight gain in eighty-six patients, ranging in age from 7 weeks to 15½ years. This beneficial action of Nilevar was observed in the patients with organic and traumatic disorders as well as those whose only complaints were poor appetite and/or persistent failure to gain weight.

In this study, the weight gained was not lost

after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

G. D. Searle & Co., Chicago 80, Illinois.  
Research in the Service of Medicine.

\*Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.

## STAPHYLOCOCCIC PULMONARY INFECTIONS\*

CAPTAIN GEORGE L. CALVY, MC, USN

The Author. Captain George L. Calvy, MC, USN, of Camp Lejeune, North Carolina. Commanding Officer, Naval Medical Field Research Laboratory, Camp Lejeune. Recipient of the Edward Rhodes Stitt Award, 1958.

IN RECENT YEARS many new and effective agents have been introduced to kill the bacteria which exist in our communities. With these powerful weapons, however, comes an increased responsibility. The infection has to be correctly identified and the proper antibiotic must be given for an adequate length of time. In the case of pneumococcal infections, recognition is relatively easy and a specific cure, penicillin, is available. On the other hand, in severe staphylococcic infections, recognition may be missed or dangerously delayed and protection by the covering antibiotic absent because of previous use of the chosen antibiotic. This has been particularly true in cases involving penicillin and streptomycin administration.

In a recent personal experience in a large hospital, more than 40 cases of antibiotic-resistant staphylococcic pneumonia, principally due to a hospital acquired strain, were diagnosed and treated during a two-year period.<sup>1</sup> They may be categorized as occurring in the following manner:

- (a) Complication of pre-existing major disease—Metastatic carcinoma, lymphoma, etc.
- (b) Post-influenzal.
- (c) Post-operative — *Key personnel*, medical, surgical or nursing may harbor pathogenic strains and/or lesions (boils, etc.) and should be screened carefully to control these accidents.
- (d) In apparently healthy hospital personnel.

In our staff, 1 medical officer, 1 nurse, and 5 corpsmen fell victim to staphylococcic pneumonia, emphasizing the communicable disease aspect of this problem. In some cases a mild "flu-like" illness had been a forerunner.

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Opinions expressed are those of the author and do not necessarily reflect those of the Navy Department.

A considerable number of staphylococcic infections, both postoperative and otherwise, were present in the hospital at this time. *Case 1:* Attention was focused sharply on the widespread and urgent character of this problem when one of our young staff hospitalmen was stricken. He had suffered from a cold and resorted to self-medication during a three-week period, using several antibiotics. His fiancée, a Wave corpsman, was hospitalized for furunculosis. He had then been exposed to a patient with staphylococcic pneumonia and soon after was admitted to the sick list with pleuritic pain and signs of pneumonia. Chest roentgenogram in the morning was interpreted as being essentially negative. A repeat film that same afternoon revealed an extensive infiltration in the right base. By the following morning roentgenographic findings revealed areas of consolidation and infiltration involving the entire right lung with extensive involvement of the left lung. A positive blood culture yielded coagulase positive staphylococcus aureus, phage type 52-42B-80/81, the so-called "hospital strain." His rapid shocking death occurred on the third hospital day, despite heroic measures. This event served to provoke action as outlined in Table I.<sup>2</sup>

TABLE I

### Task Force Staphylococcus

- I. Antibiotic Control Board — 3 agents were restricted and withheld for use in specific infections. They were chloramphenicol, novobiocin and ristocetin and were believed to be effective against our particular hospital strain.
- II. Pneumonia Team (see below).
- III. Epidemiology Center — A collecting center of information for co-ordinating the attack.

The Pneumonia Team consisted of 4 medical officers who stood a telephone watch and were available as consultants around the clock. Whenever a patient suspected of pneumonia was admitted, the medical officer got in touch with a member of the Pneumonia Team and discussed the general problem, the bacteriology of the sputum and the radiologic changes. In this manner a constant high level of clinical suspicion of staphylococcic pneumonia was maintained. The theme of this operation was "do it yourself," for the admitting doctor collected

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and examined the sputum, interpreted his patient's X-ray films and sought consultation at the earliest opportunity. Diagnosis was made earlier and treatment was standardized; tracheostomy was performed in 21 cases, both as a precautionary and as an emergency procedure. These factors are believed to have contributed significantly in curbing the mortality rate in this series. The following outline served as a useful guideline.

U.S. Naval Hospital  
St. Albans, New York

15 October 1957

### *Rationale for Pneumonia Therapy*

#### 1. DIAGNOSIS

- a) Sputum examination—done by medical resident personally.
- b) Blood culture; blood counts.
- c) Roentgenograms, as indicated—study your patient's X rays.
- d) History and physical examination.
- e) Antibiotic sensitivity tests.
- f) WBC, T.I.W., especially with ristocetin and chloramphenicol.

#### 2. THERAPY — Contact "Pneumonia Team" (Telephone Watch)

a) *Selective therapy*, when indicated, i.e. penicillin-resistant pneumococci are practically unknown . . . *pneumococcal pneumonia* is effectively treated by penicillin alone.

b) *Gamma Globulin* 10 cc I.M. every other day; 20 cc as first dose; purportedly acts to potentiate process of phagocytosis and mobilize host resistance (in fulminant infections).

c) *Staphylococcic Pneumonia* is a distinct disease with unusual and formidable characteristics. Local experience has been extensive in treating this condition. Contact "Pneumonia Watch" for guidance in antibiotic therapy for each case. There are at least two reliable antibiotics reserved for the seriously involved patient (ristocetin and chloramphenicol).

d) *Atypical (P.A.P.) Pneumonias* of viral origin do not ordinarily require antibiotic therapy when uncomplicated.

#### 3. GENERAL CONSIDERATIONS

a) Prophylaxis for "complications" is no indication for antibiotic use in the viral pneumonias.

b) Focus "on target"; select the proper arrow from your quiver and hit hard. There is a strong case for narrow spectrum antibiotics in therapy; the case against wide-spectrum antibiotics grows stronger.

#### 4. NavHosp Instruction 6710.1—Subj: Dangerous Drugs, Automatic Stop-Order of 1 July 1957.

a) Compliance with above will be observed by "flagging" antibiotic and other dangerous drug

orders and renewing same on Monday, Wednesday and Friday of each week.

b) The nurse will not stop any dose, however, without notifying the medical officer.

/s/ CHIEF OF MEDICINE

Hemolytic, coagulase-positive staphylococcal pneumonia may present as a fulminant process with death occurring before bacteriological proof can be obtained. In such instances, as Case 1, massive doses of intravenous bactericidal antibiotics should be given while awaiting bacteriological confirmation. Sputum may not be obtainable at the onset of fulminant dissemination because of its tenacious, thick consistency. The following case highlights the multiple complications and therapeutic frustrations that may attend a fulminant disseminated infection.<sup>3</sup>

*Case 2:* A 21-year-old white man was referred to the Medical Service because of pneumonia, etiology undetermined. History revealed that he had sustained a fracture of the second cervical vertebra in an automobile accident. Treatment had consisted of "prophylactic penicillin and streptomycin" and tong traction. While he was receiving these antibiotics, a secondary infection of the scalp became evident. The patient developed generalized urticaria and penicillin was stopped. Two days later he developed a fever of 106 F. and a nonproductive cough. The patient was then started on intravenous oxytetracycline, 500 mg. twice daily, with no effect. Roentgenogram of the chest revealed a right upper lobe pneumonia. Intravenous oxytetracycline was continued for two days, during which time the patient deteriorated rapidly. When received on the Medical Service he was semicomatose and cyanotic.

A tracheostomy was performed and the aspirate cultured out hemolytic staphylococcus, coagulase-positive. A culture of the scalp infection and blood cultures revealed the same organism. Chloramphenicol, 500 mg. every four hours, was started by mouth (before the culture reports were obtained), during which time the patient's condition worsened with rapid appearance of left ventricular failure and cyanosis. Intravenous sulfadiazine, 3.75 Gm. every 12 hours, was started; rapid digitalization and phlebotomy were performed, respiratory support was maintained by a Drinker respirator. During the next three days, temperature dropped by lysis and objective improvement was evident; however, on the fourth day fever of 105 F. and semicoma recurred. Sensitivity studies on the previously obtained material for culture revealed in vitro sensitivity to chlortetracycline, bacitracin, chloramphenicol, erythromycin, nitrofurantoin, neomycin, tetracycline hydrochloride, and novobiocin. In vitro, resistance was found to dihydrostreptomycin, penicillin, polymyxin B, oxytetracycline, and sulfadiazine. Erythromycin, 200 mg. every four hours intra-



muscularly, and chlortetracycline, 500 mg. every six hours, by nasogastric tube were administered with a drop of temperature to 102 to 103 F., remaining at this level. Under this regimen however, the pneumonic process extended to involve the entire right lung and the left upper lobe.

On the fifth day of this phase of the regimen, the patient had a right spontaneous pneumothorax with resulting pyothorax and open bronchopleural fistula. Subsequent antibiotics and chemical agents consisted of combinations of novobiocin, sulfadiazine, erythromycin, and streptomycin, during which time the patient developed a persistent tachycardia of 150, pericardial friction rub, electrocardiographic evidence of pericarditis, fixed specific gravity of urine, and continuous albuminuria. Fever continued between 102 and 103 F. and the spleen became palpable. A full-blown septicemia was rampant at this time.

All findings remained static until ristocetin, 1000 mg. initially and 250 mg. every six hours, was started intravenously in combination with the previously mentioned antibiotics. Ristocetin was continued with a gradual tapering in dosage for 12 days, at which time fever dropped by lysis. Evidence of pericarditis disappeared, the spleen was no longer palpable, blood cultures became negative, dissemination of the pneumonic process appeared to be arrested with localization of empyema pockets amenable to thoracentesis and closure of the bronchopleural fistula. Rapid subjective and objective improvement of the patient ensued. Ristocetin was discontinued after 12 days with no recurrence of fever, and the patient was maintained on oral novobiocin, 500 mg. every six hours, for the next two months. (This was the first local experience with ristocetin and little information was available as to its toxicity, thus the discontinuance at 12 days. Twenty-five additional cases have been treated since then for periods up to 2 months without serious reaction. A case similar to the above would now be continued on this therapy.)

#### Comment

This case demonstrates the gravity of a hospital-acquired staphylococcic pneumonia and its complications. Eighteen combinations of 10 different antibiotics and sulfadiazine were used with no apparent response except for transient response with sulfadiazine, to which resistance quickly occurred. Erythromycin and novobiocin were ineffective; however, when ristocetin was added rapid clinical improvement was noted. This man was returned to civilian life, fully recovered and is carrying on at full activity.

Early in this experience it became evident that there were radiologic characteristics peculiar to staphylococcic pneumonia, of high reliability in leading to diagnosis.

### Radiologic Findings

#### Rapid Progression — in hours.

- I. *Early*—small patches of consolidation
- II. Infiltration c circumscribed translucencies
- III. Pleural Effusion
- IV. *Typical* — pneumatocoles
- V. Spontaneous tension pneumothorax  
c or s empyema

Diagnostic features of history, physical findings and the patient's clinical appearance were utilized together with radiologic and bacteriologic findings to institute early decisive therapy.

Analysis of antibiotic sensitivities revealed most of the encountered organisms to be resistant to the sulfonamides, tetracyclines, streptomycin and penicillin.

Erythromycin enjoyed great popularity in the surrounding community, but it was ineffective in dealing with our severe staphylococcic infections. The best therapeutic results were obtained with chloramphenicol and intravenously administered ristocetin. Vigorous supportive therapy included tracheostomy. Gamma globulin was administered to 16 patients as adjunctive therapy.

A recent excellent report by Ede, Davis, and Holmes<sup>4</sup> emphasized early surgical therapy for complications. Pulmonary complications encountered in our experience were pneumothorax, empyema, lung abscess and tension cysts. Only two patients had significant respiratory disability after recovery.

During the past several years a flood of reports has appeared regarding hospital-acquired antibiotic-resistant staphylococcic infections. The following table lists known biologic characteristics of the staphylococcus which help explain its formidable nature.

### Some Biological Properties of the Pathogenic Staphylococci

#### 1. Toxins and Lysins:

- a. Lethal toxin (potent; associated with certain hemolysins)
- b. Enterotoxin (potent toxin acting primarily upon GI tract)
- c. Dermonecrotic toxin (necrotizing toxin); hemolysins?)
- alpha<sub>1,2</sub>
- d. Hemolysin (alpha, beta, gamma, delta; rbc lysins)
- e. Fibrinolysin (dissolves fibrin clots; restricted essentially to coagulase-positive human strains)
- f. Leucocidin (destroys leucocytes)

#### 2. Enzymes:

- a. Coagulase. This is regarded as *sine qua non* for pathogenicity (coagulates citated or oxalated plasma)

concluded on next page

- b. Hyaluronidase (attacks the mucopolysaccharide (hyaluronic acid) intracellular ground substance: "spreading factor")
- c. Staphylokinase (Plasminogen activator) (fibrinolysin?)
- d. Penicillinase. This is a notorious substance responsible for treatment failures (inactivates penicillin)

NOTE: Pathogenic, human (often of hospital origin), coagulase-positive staphylococci frequently belong to general phage Group III, types 80-81. These strains can further now be identified by fluorescent-antibody staining techniques.

One might reasonably pose the question, why does an antibiotic fail? In many instances it is apparent that antibiotic failure is blamed when a temperature fall has not been as rapid or as convincing as a physician would wish. A recent discussion with Dr. Monroe Romansky<sup>5</sup> and a report by Alling and Pulaski<sup>6</sup> have summarized *causes of failure* to include the following:

1. The use of antibiotics as substitutes for surgery. Fundamental surgical principles simply cannot be ignored, i.e., incision and drainage.
2. The causative organism not being sensitive to the antibiotic employed.
3. Presence of emerging strains of bacteria, resistant to the antibiotic.
4. Alteration of the bacteria flora during treatment (leading to superinfection).
5. Inaccessibility of the lesion so that the therapeutic agent cannot be brought into contact with it. Chronic infections, bony sequestra, and infections surrounded by a protective membrane are examples of this difficulty.
6. Inadequate dosage. In certain situations, low doses may actually stimulate the growth of bacteria; inadequate dosages may merely arrest the growth of the bacteria, whereas the indicated blood level of antibiotics would be bactericidal.
7. Too early withdrawal of therapy.

In general, when dealing with severe staphylococcal infections, a focus on target with a narrow spectrum antibiotic is recommended for best results. Success with ristocetin may be largely attributed to this factor.

Awareness of the manifestations and gravity of staphylococcal pneumonia, with attention to early diagnosis and decisive therapy, both medical and surgical, is to be emphasized as essential for the successful management of this disease.

Reversal of the attitude of complacency that has come to prevail during our enlightened antibiotic era is an urgent matter. Attention to fundamentals of asperis with more emphasis rather than less accorded this basic precept will surely go far in suppressing, if not eradicating, these infections.

#### BIBLIOGRAPHY

- <sup>1</sup>Schumacher, L. R.; Coates, J. R.; Sowell, R. C.; and Calvy, G. L.: Staphylococcal Pneumonia: A Clinical Evaluation of 40 cases. Clin. Research, Vol. 7, No. 2, p 267, April 1959
- <sup>2</sup>Calvy, G. L.: Stalking the Staphylococcus. N. E. Jr. Med. 259:532-534 (Sept. 11, 1958)
- <sup>3</sup>Taylor, D. E.; Schumacher, L. R.; Sowell, R. C.; and Calvy, G. L.: Antibiotics Annual, 1957-1958. Staphylococcal Pneumonia
- <sup>4</sup>Ede, S.; Davis, G. M.; and Holmes, F. H.: Staphylococcal Pneumonia. J.A.M.A. Vol. 170, No. 6, June 6, 1959 pp. 638-643
- <sup>5</sup>Romansky, M.: Personal Communication
- <sup>6</sup>Alling, C. C.; and Pulaski, E. J.: Oral Surgery, Oral Medicine and Oral Pathology, Vol. 12, No. 6, June 1959

There is a long tradition of the physician's setting his own fees without having to explain to the Blue Shield or to an insurance company why a prolonged, complicated, and worrisome case merits a higher price tag. There is a natural resentment if the agent has sold the patient an inadequate type of policy, perhaps using deliberate deception as to the benefits. Among other worries which beset the private practitioner are the inroads made by closed-panel prepayment plans of labor groups, welfare funds, and the Veterans Administration. Here selected physicians are used, and freedom of the choice of other doctors is denied the insured. The threat of socialized government-controlled medicine is now a dark cloud on the physician's horizon. He is conscious of the plight of his brother physicians in England and Scandinavia. The recent landslide victory of the Conservative free-enterprise party in Britain indicates to him that the other great English-speaking country is fed up with socialism. The American doctor looks to insurance companies to provide a solution for the high cost of medical care through proper financing. He is beginning to realize that insurance helps his patient to pay his bills without attempting to dictate the type of care.

As physicians begin to appreciate our efforts to solve the problems of medical economics by health insurance prepayment plans, they look with particular favor on the major medical and comprehensive plans. In turn, we are educating them to the need for curbing abuses such as over-charging and the over-use of hospital facilities.

One of the greatest sources of irritation to the physician is the amount of paper work. For a single patient this can be cumulatively mountainous. Health evidence may be necessary not only for insurance and disability claims, but for birth, marriage, periodic check-ups, pre-employment, health problems at work, foreign travel, military service, retirement pension, and social security. Mindful of this patient's social and economic welfare, the modern physician must maintain good medical records. Obviously, anything we can do to ease his clerical burden is a godsend. As you know, we have made real progress in this respect in the development of uniform claim forms and in designing a simplified attending physician's statement to be used for his life insurance application. So far, 80% of the insurance companies have co-operated; with the help of the medical directors, we aim for an even higher figure.

... J. GRANT IRVING, M.D., *Chairman*, Medical Relations Committee, Health Insurance Council, in an address to the 68th annual meeting of the Association of Life Insurance Medical Directors of America, at New York, October 23, 1959.



## COMBINED LEFT VENTRICULAR AND SUPRASTERNAL PERCUTANEOUS PUNCTURE IN ASSESSMENT OF MITRAL AND AORTIC VALVE DISEASE\*

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RECENT ADVANCES in cardiovascular surgery have demonstrated the need for precise methods of evaluating altered function of the left heart. Direct needle puncture of the left ventricle, atrium and aorta makes possible the recording of pressure pulse tracings, as well as blood oxygen concentrations from these chambers, which are not ordinarily accessible to venous catheterization. When necessary, contrast media can be injected through the needle and the morphology of the left heart structures studied with the aid of serial X-ray films. Similarly, the injection of indicator dyes or radioactive isotopes and their subsequent recovery from the right heart or peripheral venous or arterial systems may provide additional useful information.

It is the purpose of this paper to review the history of left heart puncture, outline some of the techniques employed to obtain these physiologic data, present the technique we feel to be the safest and technically most satisfactory, and review our experience with six patients studied at the Rhode Island Hospital.

### History

In 1953, Bjork<sup>1</sup> (Sweden) reported a method of percutaneously puncturing the left atrium from the back. A 20 cm. needle with a 1 mm. bore and 1.5 mm. outer diameter was introduced along the upper border of the right ninth rib 5 cm. to the right of the spinous process. Fluoroscopic examination and a typical pressure tracing confirmed the correct positioning of the needle within the left atrium. A thin polyethylene or polyvinyl catheter was then introduced through the needle into the left atrium. With manipulation, the catheter was passed through the mitral valve into the left ventricle and sometimes through the aortic valve into the ascending aorta. Reported complications of this procedure

were: rupture of intercostal artery causing a hemothorax, mild pneumothorax, hemopericardium, and pulmonary hemorrhage.

Puncture of the left atrium through the left main stem bronchus was developed by Allison & Linden in 1953<sup>2</sup> (England). After a bronchoscope was passed to the carina, a 5-6 cm. long, 0.3 cm. bore needle was introduced through the anteromedial wall of the left main stem bronchus and correctly positioned under fluoroscopic guidance. Although reported complications have been minimal, the disadvantage of this technique was that other left heart chambers could not be entered.

Percutaneous left ventricular puncture was developed and refined by Reboul and Racine,<sup>3</sup> Ponsdomench and Nunez,<sup>4</sup> and Smith, et al.,<sup>5</sup> working first with dogs and subsequently with human subjects. In 1956, Sir Russell Brock<sup>6</sup> reported his experiences with left lateral percutaneous puncture of the left ventricle in twenty-four patients without mortality or serious morbidity. Using this method in conjunction with retrograde aortic catheterization it was possible accurately to determine the gradient across the aortic valve. An 18-gauge needle was introduced directly through the chest wall 2 cm. below and lateral to the apex beat and advanced into the left ventricle pointing towards the second right costochondral junction with a backward inclination of 35°. In 1957, Lehman<sup>7</sup> refined the technique of subxiphoidal percutaneous left ventricular puncture and reported his experience in seventy-seven patients. Although there is no mortality associated with this method, a significant number of patients accumulate a small amount of serosanguinous pericardial fluid which was found to be present at subsequent operation. Many patients complained of mild chest discomfort for several days.

Stig Radner<sup>8</sup> (Sweden) in 1955 reported a method for serial entry of the aorta, pulmonary artery and left atrium with a long needle introduced percutaneously through the suprasternal notch. The safety of the suprasternal puncture with piercing of both main arterial trunks depended upon the fine caliber of needle used. Radner advised against using a needle larger than 0.8 mm. in outside diameter. In forty-nine patients who were studied by Radner, no serious complications were reported.

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### Technique

At Rhode Island Hospital the technique employed for the study of the dynamics of the left heart has been derived with minor modifications from the combined methods of Lehman and Radner. Since the six patients reported here have been adults, a combination of 50 to 100 mg. Demerol and 0.1 gm. Nembutal has been administered one hour prior to the proposed procedure. All patients underwent routine right-heart catheterization through an arm vein to determine the cardiac output by the Fick Principle. At the completion of the right-heart catheterization the patients were further sedated by giving approximately 25 mg. of Demerol intravenously in preparation for the direct needle punctures. Local anesthesia (1% Procaine) was employed at the site of needle puncture. The patient was placed in a supine position with head extended and turned to the left. The suprasternal needle was connected through a three-way stopcock to a weak Heparin (50 mg. to 1000 cc. 5% D/W) drip and to a Sanborn pressure transducer and 4-channel Polyviso Recorder. It was then advanced through the suprasternal fossa at an angle predetermined from frontal and lateral chest roentgenograms so as to enter the aorta, pulmonary artery and left auricle serially (Figure 1). With the Radner needle in the left atrium, a 6-inch short-beveled #18-gauge needle was then inserted beneath the xiphoid cartilage and directed at a point halfway between the estimated position of the mitral valve and apex of the left ventricle. The right ventricle was usually entered first and the needle advanced further through the interventricular septum into the left ventricle (Figure 2). The location of each needle was checked by the characteristic pressure-pulse tracing obtained. Figure 3 illustrates the flexible #20-gauge suprasternal needle\* and the #18-gauge

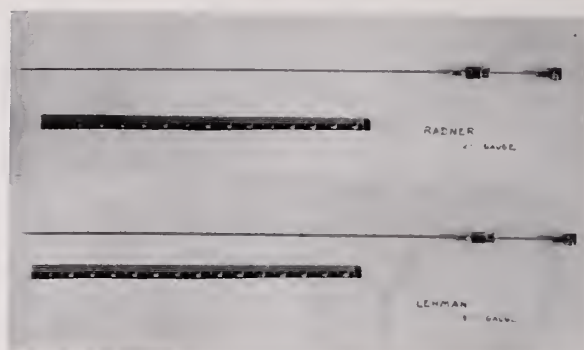


FIGURE III

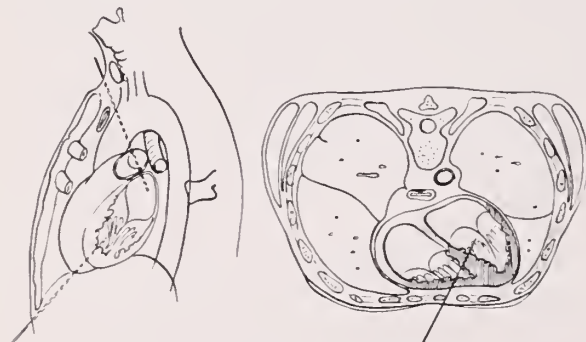
#20 gauge suprasternal needle of Radner and #18 gauge ventricular needle of Lehman.



FIGURE IV

Both needles in position.

ventricular needle. Figure 4 demonstrates both needles in place. The electrocardiogram was continuously monitored throughout the procedure. With the needle in place, left auricular and left ventricular pressure-pulse tracings were obtained. The suprasternal needle was then withdrawn into the aorta so that simultaneous left ventricular and aortic pressure-pulse tracings were obtained.



FIGURES I and II

Radner's needle in place as it pierces the aorta, pulmonary artery and left auricle, and Lehman's needle, the tip of which is in the left ventricle.

Cross section of the thorax with the tip of the ventricular needle in the left ventricle, having pierced the right ventricle and septum.

### Illustrative Cases

#### Case I

D.H.: A twenty-nine-year-old male carpenter had had a heart murmur since childhood. He had been refused life insurance and had been rejected from military service because of this murmur. One year before admission, he sustained a back injury in an automobile accident and developed complaints of easy fatigability, occasional tightness of the anterior chest, heartburn and symptoms of anxiety. Since that time he had been unable to work more than four hours per day.

Physical examination revealed a B.P. of 120/70 and a regular pulse rate of 68. The heart was not

\*Made especially for us by the Becton and Dickinson Company.

enlarged. There was a harsh, Grade III, systolic murmur loudest at the base and transmitted into the neck vessels, over the precordium and to the upper back. A Grade I, early diastolic, decrescendo murmur was heard along the left sternal border. A-2 was greater than P-2. The electrocardiogram and roentgenograms of the chest were within normal limits. Left ventricular puncture revealed a pressure of 135/0. A pressure of 135/60 was recorded from the left brachial artery.

Since there was no systolic gradient across the aortic valve, this patient was felt to have insignificant aortic stenosis.

#### Case II

W.McC.: A twenty-three-year-old male had had known rheumatic heart disease since childhood. He had recently begun to complain of dyspnea after climbing two flights of stairs. Physical examination revealed a B.P. of 92/60 and a regular pulse rate of 84. His heart was enlarged to the left anterior axillary line. A-2 was diminished. There was a Grade III harsh, systolic aortic murmur with an associated thrill. The murmur was transmitted into the neck and anterior chest. A Grade III systolic murmur of somewhat different quality could be heard at the apex where there was a Grade II diastolic rumble. An opening snap was heard. Roentgenograms of the chest and chest fluoroscopy revealed left ventricular and left auricular enlargement. Electrocardiograms suggested right ventricular hypertrophy. Left-heart puncture revealed a systolic aortic gradient of 144 mm. Hg. The cross-sectional aortic valve area was calculated to be 0.4 sq. cm. Since 0.6 cm.<sup>2</sup> is considered to be the critical cross-sectional area, surgical correction of his lesions was advised. Several weeks later he developed auricular fibrillation. Subsequently, with the aid of a pump-oxygenator, he underwent open aortic and mitral valvulotomy with gratifying results.

#### Case III

G.M.: This eighteen-year-old male had had an aortic systolic murmur discovered four years before admission, although he gave no history of acute rheumatic fever. His only symptoms had been mild fatigue and minimal dyspnea and he had been doing strenuous manual labor. Physical examination revealed a B.P. of 110/70 and a regular pulse rate of 64. The heart was not enlarged. There was a harsh, Grade III, systolic aortic murmur heard well over the precordium and well transmitted into the neck vessels. A-2 was greater than P-2. The electrocardiogram was suggestive of left ventricular hypertrophy. Roentgenograms of the chest and chest fluoroscopy were normal. Left-heart puncture revealed a systolic aortic gradient of 90 and the cross-sectional aortic valve area was calculated to be 0.9 cm.<sup>2</sup>

This patient was considered to have moderate aortic stenosis with a borderline aortic valve size not requiring surgery at this time.

#### Case IV

E.R.: A twenty-year-old asymptomatic male who had a known aortic systolic murmur since 1953; but who did not give a history of acute rheumatic fever. He was able to do heavy labor without difficulty. Physical examination revealed a B.P. of 110/85 and a regular pulse rate of 70. The heart was not enlarged. A harsh, Grade II, systolic murmur was heard at the base and was well transmitted into the neck vessels. There was an associated systolic thrill. The electrocardiogram was normal. Roentgenograms of the chest were normal. Left-heart puncture revealed a systolic pressure gradient of 75 mm. Hg. across the aortic valve.

It was felt that this patient had moderate aortic stenosis and that surgery was not indicated at this time.

#### Case V

D.A.: A forty-eight-year-old female, who gave no history of acute rheumatic fever, had been asymptomatic until age forty when she first noted slowly progressive fatigue and dyspnea. Five years before admission a diagnosis of rheumatic heart disease was first made. Physical examination revealed a B.P. of 100/60 and a regular pulse rate of 84. The heart was enlarged to the left. P-2 was greater than A-2 and M-1 was accentuated. There was a harsh, Grade II, systolic, aortic murmur transmitted into the neck vessels and well heard in the axilla. A Grade II-III, mid-diastolic, apical rumble with presystolic accentuation and an opening snap were heard at the apex. The electrocardiogram was normal. Roentgenograms of the chest and chest fluoroscopy revealed right ventricular enlargement, left atrial enlargement and calcification of the mitral valve annulus. The left ventricle was not enlarged. Left-heart puncture revealed an aortic systolic gradient of 77 mm. Hg. and a mitral diastolic gradient of 11 mm. Hg. The pressure-pulse tracings did not show evidence of mitral regurgitation.

It was felt that this patient had significant aortic and mitral stenosis requiring combined operative correction.

#### Case VI

D.F.: This forty-three-year-old female had had acute rheumatic fever at age twenty but had done well until one year before admission. At that time she developed progressive symptoms of dyspnea on exertion, orthopnea, paroxysmal nocturnal dyspnea and intermittent ankle edema. Physical examination revealed a B.P. of 130/65 and a regular pulse rate of 80. The heart was not enlarged. A-2 was faint

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and M-I was accentuated at the apex. There was a Grade IV, harsh, aortic systolic murmur which was transmitted into the neck vessels and toward the apex. A Grade II, diastolic, apical rumble was heard at the apex, while a Grade I, diastolic decrescendo murmur was heard along the left sternal border. The liver was palpable two fingerbreadths below the right costal margin and the neck veins were slightly distended. An electrocardiogram showed non-specific ST-segment depression, while roentgenograms of the chest and chest fluoroscopy revealed left atrial enlargement, right ventricular enlargement and questionable left ventricular enlargement. Left-heart puncture revealed an aortic systolic gradient of 44 mm. Hg., with a mitral diastolic gradient of 5 mm. Hg. (Figures 5a and 5b). The aortic valve cross-sectional area was 1.03 cm.<sup>2</sup> while the mitral valve cross-sectional area was 1.4 cm.<sup>2</sup>

It was felt that this patient had both mitral and aortic stenosis and should have combined operative correction of these two lesions.

### Discussion

Our present technique evolved gradually. Patient I did not have right-heart catheterization to calculate cardiac output or suprasternal puncture of the left atrium or aorta, while patients II and III had retrograde aortic catheterization.

Two of the patients reported above had murmurs consistent with aortic stenosis but were not found

to have significant narrowing of their valves. The prognosis in these patients is good without further treatment at this time. Another patient with moderate aortic stenosis may require corrective surgery in the future.

The remaining three patients had combined valvular lesions. The need for concomitant corrective surgery of both valves can be more fully determined as a result of these studies. Two of the six patients presented illustrate that a loud murmur is not an infallible indication of seriously disordered valve function in physiologic terms.

These studies are indicated in all cases of aortic stenosis since aortic valvulotomy is more successful before the patient has seriously deteriorated and developed severe left ventricular failure. Past experience has shown that a cross-sectional area of less than 0.6 cm.<sup>2</sup> is associated with progressive deterioration and the patient's early demise. These studies should aid the early selection of those patients requiring valvulotomy.

This technique is not wholly satisfactory for evaluating mitral regurgitation. Left ventriculography is more helpful in evaluating this lesion. Radiopaque dye (Diodrast) is injected through the left ventricular needle and regurgitant opacification of the left atrium evaluated with rapid serial radiography.\*

\*Six/sec. (Schenander-Stockholm, Sweden)

### SUMMARY

(1) The history and various techniques in the study and assessment of mitral and aortic valve disease have been presented.

(2) Six cases who had been studied at Rhode Island Hospital have been presented and discussed. Our experience to date suggests that these studies are valuable in the diagnosis of the severity of mitral and aortic stenosis, but are not adequate in evaluating mitral regurgitation. For the latter, ventriculography provides a more accurate means of objective assessment of the presence and degree of mitral valvular insufficiency.

(3) These techniques may rule out significant aortic valvular pathology, though the patient may have a loud, harsh aortic systolic murmur.

### REFERENCES

- <sup>1</sup>Bjork, V. O.: Direct pressure measurement in the left atrium, the left ventricle and the aorta. *Acta Chir. Scandinavica*, 107:466, 1953
- <sup>2</sup>Allison, P. R.; Linden, M.B.: The bronchoscopic measurement of left auricular pressure. *Cir.* 7:699, 1953
- <sup>3</sup>Reboul, H., and Racine, M.: La ventriculographie cardiaque experimentale. *Presse Med.*, 41:763, 1933
- <sup>4</sup>Ponsdomench, E. R., and Nunez, B. V.: Heart puncture in men for diodrast visualization of ventricular chambers and great arteries. I. Its experimental and anatomophysiological bases and technique. *Am. Ht. Journal* 41:643, 1951

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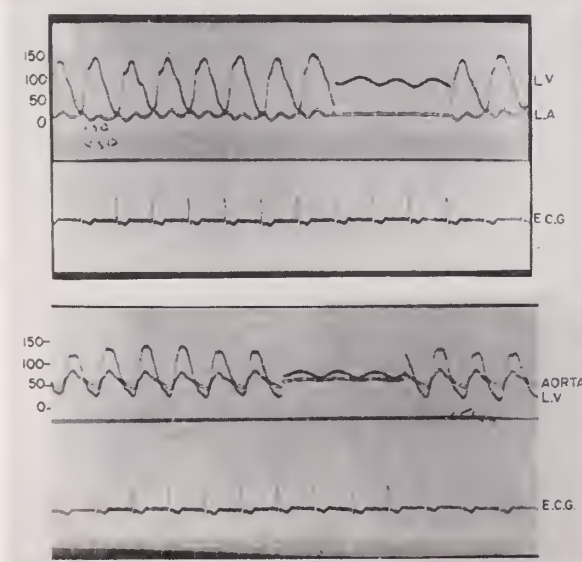


FIGURE V (a)

D. F., a 43-year-old female. Superimposed LA and LV tracings. Mitral diastolic gradient of 5 mm. Hg.

FIGURE V (b)

Superimposed LV and aortic tracings. Aortic systolic gradient of 44 mm. Hg.



## THE HOSPITAL AT PORTSMOUTH GROVE\*

SEEBERT J. GOLDOWSKY, M.D.

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MANY VETERANS of World War II knew Lovell General Hospital as a vast, efficient installation, located at Fort Devens, Massachusetts. Few would be aware that there had been an earlier hospital of the same name in Rhode Island during the Civil War. The first Lovell General Hospital, established at Portsmouth Grove on Aquidneck Island in the second year of the conflict, was, during its brief career, an important part of the local scene.

On July 6, 1862, a pleasant and peaceful Sunday morning, there arrived suddenly and unexpectedly in Newport Harbor the first of two transports loaded with casualties from the battle areas to the south. With their arrival the actuality of war came to the placid and complacent countryside with explosive force, prompting a reporter at the scene to comment: "The stern realities of war are now brought to our own doors." The excitement and confusion which followed were epic.

The steamer *America* arrived at 8:00 A.M., the steamer *Atlantic* following later at about 5:00 P.M., bringing in all some 1,724 sick and wounded. These were casualties from the Army of the Potomac, evacuated from the hospital at Yorktown, Virginia. The decision to bring them north had been improvised under the pressure of military necessity. Virtually no preparations had been made for their arrival.

Proceeding to Portsmouth Grove, several miles up the bay, the vessels reached their destination an hour or so after entering the harbor. Notice of the arrival of the first ship having been quickly disseminated through the town of Newport, every conceivable conveyance started for Portsmouth Grove. Carriages, wagons, omnibuses, and sailboats set out jam-packed with citizens laden with cakes, pies, jellies, milk, lint and clothing. Others who had no means of transport traveled on foot. There were an estimated eighteen hundred citizens, including a group of physicians, on the road that day, "more in

\*Read before a joint meeting of the Providence Medical Historical Society and the Benjamin Waterhouse Medical History Society at Boston, Massachusetts, on March 16, 1959.

fact," as one observer remarked, "than had been since the British and Hessian troops occupied the Island during the Revolutionary war." It was, incidentally, one of the hottest days of the year.

The horde, descending upon Portsmouth Grove, offered to help unload patients and supplies, but their services were peremptorily refused. The steamer *America*, which had arrived first, was under the command of the executive officer, Dr. G. C. Striebling, while the commanding officer, Dr. Francis L. Wheaton, was still at sea on the steamer *Atlantic*. Striebling is reported to have told the teeming throng that their services "were not needed"; at any rate he would not allow the sick to be moved. This was interpreted as callous indifference to the suffering of the brave lads.

The plain fact is that he probably lacked the authority to act in the absence of his commanding officer; but the emotional mob were in no mood to make allowance for orderly military procedure or the protocol of rank. Angry and frustrated, most of them returned to Newport.

Upon the arrival late in the afternoon of the steamer *Atlantic*, the bay steamer *Perry* sailed for the Grove from Newport with four hundred determined people on board. Surgeon Francis L. Wheaton was now in command. "After some sharp talk between the surgeon and our citizens," according to a contemporary news story, "they were allowed to assist in carrying tents, &c., to the shore." The landing of the casualties, however, did not commence until Monday morning. Progress was slow, as might be expected, but by Thursday all were on shore and had been placed in reasonably comfortable quarters. This in brief is the story of the origin of the hospital at Portsmouth Grove.

These incidents were followed by a sharp controversy in the press in which the conduct of those concerned was criticized severely and bitterly. The episode can be more objectively appraised, if we explore briefly its historical background.

The ill-fated Peninsular Campaign, which provided the cast for this drama, had gotten under way early in April of 1862. General George B. McClellan argued that an operation on the Peninsula lying between the York and the James Rivers in Virginia offered the shortest route to Richmond. The roads on the Peninsula, he reasoned, were passable at all

*continued on next page*

seasons and there were few natural obstacles in his path. Gunboats on the rivers could protect his flanks, while in the unlikely event of defeat, he could fall back on Fortress Monroe at the mouth of the James River, his southern and left flank. He was fatally wrong in all respects except the last. The Peninsula, fifteen to seventeen miles wide, is marshy and thickly wooded, and is cut by many small streams. Their estuaries are flooded by the tides, while their upper reaches broaden into swamps which, in the spring rains, become a miasmatic morass. Richmond was seventy miles from tidewater.

McClellan began landing his forces at Fortress Monroe on April 1. One month later, on May 5, Yorktown, at the mouth of the York River, his northern flank, fell without a battle and after a fruitless siege. He set up his communications zone bases at Yorktown and Fortress Monroe. These establishments included hospital facilities.

His subsequent advance up the Peninsula carried him to within six miles of Richmond. On the way he established advanced bases at Harrison's Landing on the James, and at White House Landing on the Pamunkey River, a tributary of the York, the latter becoming his personal headquarters. As he continued his forward progress his forces became split by the treacherous Chickahominy River, a tributary of the James, into northern and southern sectors. The Chickahominy was an erratic and sluggish stream spreading out into swamps and flowing around many islands, forming a valley from a half mile to a mile in width. In dry weather it is hardly more than a brook, but only moderate showers could convert it into a formidable obstacle. To keep communications open between his right and left flanks, McClellan devoted precious time to the building of bridges across this stream.

On the night of May 30, the rains, which had already been sufficiently heavy to convert the reputed "all-weather" roads to boggy and sticky messes, came with a vengeance. It was one of the worst storms in the memory of man, and all but one of the bridges went out. Although for a time McClellan was able to keep up his pressure on Richmond, his position became increasingly untenable. During the early weeks of June he had already given thought to the desirability of transferring his base from White House Landing on the York to Harrison's Landing on the James, thus consolidating his forces south of the treacherous Chickahominy. He had initiated preliminary planning with that objective as early as June 18. President Lincoln, who was, of course, never happy about the Peninsular venture, had expressed misgivings about the deployment of McClellan's troops. Suddenly on June 26, Lee, who had but recently been designated commander-in-chief of Confederate

forces, struck a sledgehammer blow at McClellan's right north of the Chickahominy, aimed at his base at White House Landing. It was that night that McClellan gave orders to withdraw to his new base at Harrison's Landing to the south.

### *... Seven Days' Battle*

The rest of the week was devoted to a desperate holding action known as the Seven Days' battle, while a difficult, massive and complicated retreat was carried out in the mud. The redeployment, and in fact the battle itself, came to an end on July 1. The retreat was in many respects a memorable military undertaking, but for all practical purposes it put an end to the Peninsular Campaign.

With the whole countryside a quagmire, combat conditions were beyond belief. In the sweltering heat of June the malarious swamps and the polluted waters of the sluggish streams became veritable fountains of disease. Malaria and typhoid stalked the ranks. The death rate was appalling, and the hospitals were under extreme pressure. Jonathan Letterman,\* who at this very juncture came upon the stage, has recorded these vivid observations of the scene: "In obedience to orders from the War Department, dated June 23, 1862 I reported on the 1st day of July to Major-General McClellan at Haxhall's Landing, on the James River, for duty as Medical Director of the Army of the Potomac, and on the 4th took charge of the Medical Department of that army.

"On arriving at the White House, June 28th, I found there was no communication between that depot and the headquarters of the army, then en route for James River. . . . It was necessary that the medical supplies and the transports for the wounded and sick should be sent up the James River to meet the wants of the Army." Unable to obtain the requisite orders from Surgeon Tripler, whom he was to succeed as medical director, the telegraph wires having already been cut, he ordered the medical director of transportation to proceed up that river with the available supplies and vessels with all possible dispatch. "They reached Harrison's landing in time to be of the greatest service. The troops for several consecutive days and nights had been marching and fighting among the swamps and streams which, abounding in this part of Virginia, render it almost a Serbonian bog.\*\* The malaria arising from these hotbeds of disease began to manifest its baneful effects upon the health of the men when they reached Harrison's Landing. The labors of the troops had been excessive, the excite-

\*Creator of the famed "Letterman Plan" for the evacuation of sick and wounded upon which the modern system of medical evacuation has been based.

\*\*The Serbonian bog was a marsh near Lake Serbonis in ancient Egypt famous for engulfing travelers. Lake Serbonis is now a dry lake.



ment intense; they were obliged to subsist upon marching rations, and little time was afforded to prepare the meagre allowance. They seldom slept, and even when the opportunity offered, it was to lie in the mud with the expectation of being called to arms at any moment. . . ." Due to their prolonged subsistence on inadequate rations scurvy was rampant.

While these grandiose events were taking place, less dramatic moves were being made which have a more direct bearing on our story. On June 8, two interesting communications went forward from the office of William A. Hammond, surgeon general of the United States Army. The first was a letter directed to Surgeon C. S. Tripler, then Medical Director of the Second Army of the Potomac:

Surg: Genls Office  
June 8, 1862

Sir:

As it is manifestly apparent that the General Hospital at Yorktown is most disadvantageously situated in almost every respect, it is deemed necessary for the well being of the sick that this Hospital should be removed.

You will therefore at the earliest practicable moment direct the Medical Officer in charge to abandon the buildings at that place and remove the tents with his whole staff to the vicinity of Fortress Monroe, and with this view you will direct him to select a site and make requisition on the Quarter Master's Department for shed Hospitals in addition to the tents. The plans for these sheds will be furnished from this Office.

I am Sir, Very respectfully,

Yr: ob: St.

W. A. Hammond

Surg: Genl. U.S.A.

The second went to General M. C. Meigs, quartermaster general of Federal Forces:

Surg: Genl. Office  
June 8, 1862

General:

I have the honor to inform you that I have instructed Surgeon Tripler to break up the General Hospital at Yorktown and to remove the whole establishment to the vicinity of Fortress Monroe. I have to request that you will direct sheds to be erected at the point to be selected, capable of accommodating about 1000 men. With the tents now on hand there, 2000 men can be accommodated. I have also directed Surgeon Cuyler to abandon the Hygeia Hospital which I understand is rented at 1000 dollars per month, and to move this establishment to tents and sheds. I have therefore to request that the necessary sheds for 1000 men may be as soon as possible erected. I will furnish you with plans for these sheds immediately.

By the adoption of the plan above specified, the transportation of the sick north will be in a great measure avoided, the health of the sick and wounded improved, and the abatement of the great nuisances — the Hygeia Hospital and the General Hospital at Yorktown — secured.

I am Sir, Very respectfully &c

W. A. Hammond

Surg: Genl. U.S.A.

These orders are interesting in several respects. In the first place they antedated by some eighteen days the final retreat orders issued on June 26. Furthermore the observation that the hospital at Yorktown "*is most disadvantageously situated in almost every respect*" was peculiarly prophetic. It is not unreasonable to conclude that the contemplated move of the hospital from the York to the James was motivated to some extent at least by the strategic considerations previously discussed, even though no official records are available which confirm this view.

The Hygeia Hospital at Fortress Monroe was located in a requisitioned hotel of the same name. The hotel's name seems to have been somewhat prescient, although at the time of these events its appropriateness would seem to be somewhat doubtful in view of its being characterized as a "great nuisance."

The transfer of the medical installations ordered on June 8 "at the earliest practicable moment" seems to have met considerable delay, probably inevitable in view of the existing military and logistical situation. At any rate at the close of the Seven Days' battle on July 1 the casualties quartered at Yorktown had not yet been moved. After the recapture of White House Landing by the Confederates and the retreat of Union forces south of the Chickahominy, Yorktown would inevitably and promptly be over-run. There were in its hospital in excess of seventeen hundred sick and wounded in various stages of convalescence. None of these had participated in the most recent battles.

#### *Dr. Wheaton, Medical Officer*

The medical director at Yorktown was Dr. Francis L. Wheaton of Providence, Rhode Island, son of the eminent Dr. Levi Wheaton and a graduate of the Medical School at Brown University in the class of 1826. He had served as a surgeon in the Mexican War in 1847 and had completed four terms as surgeon general of Rhode Island. At the outbreak of the War of the Rebellion, he had been one of the first to respond. Both his military and his medical background were impressive.

Dr. Wheaton received orders to evacuate the hospital at Yorktown forthwith. The scenes which followed are well described in excerpts from an official report:

*continued on next page*



"In accordance with military orders received by the Medical Director in charge at Yorktown, we were advised, that the entire Hospital was to be immediately removed to two Steamers, lying in the York river, the 'America' and the 'Atlantic,' and on the morning of the third of July, we were requested to be at our respective places of duty at an early hour, and assist in the removal of the sick and wounded, hospital stores, baggage &c. The Medical Director, remaining upon the wharf the entire day, gave his personal attention to the loading of the 'America' which was completed at seven o'clock in the evening, and he then took his position on board of the 'Atlantic' lying in the stream, and unable to approach the wharf, and personally directed the disposal of the men, as they were conveyed to the steamer in a transport.

All were safely on board of the 'Atlantic' on the morning of the fourth: the stores however, were not all received on board until late in the afternoon, and our departure was delayed until daylight on the morning of the Fifth.

It was expected, that the 'America' would sail in company with us, but she left on the afternoon of the fourth of July, with positive orders, as we were afterwards informed, to await our arrival at Newport and to have no communication with the shore.

The orders were disobeyed, and on our safe arrival at Portsmouth Grove, R. I. on the evening of the sixth of July, she was lying at anchor there."

A newspaper report stated that Wheaton had received orders to proceed to Fortress Monroe from Yorktown, but upon arriving there found no accommodations and assumed the responsibility of proceeding to Newport. A later account stated, probably more accurately, that he had been ordered at Monroe to move on. It has not been possible from official sources to determine which if either of these accounts is correct as no written orders have been found. It is reasonable to assume, however, that the situation at Fortress Monroe was one of extreme activity and possibly of utter confusion, with the whole of the Peninsular armies retreating there in force. The casualties of the Seven Days' battle totaled over 15,000, of whom over 8,000 were wounded. About 2,500 sick and wounded and many hospital stores were abandoned to the enemy at Savage Station. The remaining 6,500 casualties eventually found their way to Harrison's Landing and Fortress Monroe. The precipitate nature of the retreat is indicated by the fact that, among the booty, 31,000 small arms alone were captured. Dr. Wheaton and his convalescents were probably not a welcome sight at Fortress Monroe.

Some weeks earlier at the request of Governor

Sprague inspection of various sites on Narragansett Bay had been made with a view to establishing an army general hospital in this state. The location, accessibility and reasonableness of terms had recommended Portsmouth Grove, a small summer resort, as the most eligible location. The recommendation was received favorably by the Federal government and according to town records in Portsmouth, a lease was signed with the owners effective June 1, 1862 by William W. McKim, assistant quartermaster of the United States Army. The lease was renewable annually at the pleasure of the government. Dr. Wheaton was undoubtedly aware of these facts, and the foresight of the local authorities provided for him and his charges a welcome and convenient refuge in the emergency.

### *Portsmouth Grove Selected*

Messages were telegraphed ahead to Mayor Cranston of Newport that the transports were on their way to Rhode Island and he was requested to station pilots in the harbor for the purpose of directing them to Portsmouth Grove. Much of the early confusion upon arrival was created by an unidentified surgeon landing at Newport and requesting aid. The official report indicates, as previously noted, that this action was unauthorized, and that the seeming intransigence of Executive Officer Striebling was probably in accordance with his orders. Upon the arrival of Dr. Wheaton, unloading of the transports began in earnest. Until their arrival, the troops had been under the impression that the armies in the field had been totally annihilated, having received no word of the battle since sailing from the Peninsula. When they learned that the enemy had indeed been held successfully, they let up a great cheer. This intelligence boosted their morale even more than the fresh air.

According to the official report, the "voyage was an exceedingly pleasant one, few suffering from sea-sickness, and all being cared for, as well as the military necessity of our hasty removal would allow." The newspaper reports confirmed that the passage had been quick and easy, and that the weather was fine and the sea smooth. In other respects, however, the trip was extremely uncomfortable. Over 1,700 men, many seriously ill, were crowded into two vessels, which to our modern eyes, would undoubtedly seem small, although at the time they were described as "immense." The air between decks and in the holds was hot and stifling and the more severely ill suffered extremely. Two died en route and were buried at sea. But Dr. Wheaton had done what he could to make the men comfortable. There were nine surgeons on board and one hundred eight nurses detailed from the several regiments. The hospital stewards and nurses, all male, were distributed about the ships with definite assignments, and attention was given, as far as fea-

ible, to the cleanliness of the men and the sanitary condition of the ships. Despite these efforts, many were ragged and dirty, even lousy. With patients suffering from malaria, typhoid, diarrhea and infected wounds, the stench in the close quarters was terrible.

Dr. Wheaton, late Sunday afternoon, ordered the unloading of some tents and other equipment; but the debarkation of patients did not begin until Monday morning. The first day about forty of the sick-est were brought ashore, including two or three wounded, and these seemed to be much relieved by exposure to the fresh air. The unloading was of necessity a slow and laborious procedure, although the citizens exhibited much impatience over the delays. Many of the sick could walk, some on crutches, but many others had to be brought ashore on litters. The shallow waters required the steamers to remain at anchor and the discharge of cargo was accomplished with the aid of steam tugs and lighters. By Thursday morning all were on shore and placed in comfortable quarters. Soon after arrival the medical officers had, according to the quaint custom of the military, appropriated the small hotel building on the grounds for their own quarters, causing bitter criticism among the bystanders.

The tents were pitched on the lawn south of the hotel and were cooled by the prevailing southwest winds. They were mostly large hospital tents, placed in pairs, so that each unit accommodated sixteen to twenty patients. The cots were of iron with wooden slats and straw mattresses. In the confusion men were often landed before there were beds available, and tents were landed without poles. As a result of the disorganization some of the men were left lying on litters, some on the ground exposed to the burning July sun. Gradually, however, the situation improved.

By the end of the first week some twenty more of the patients had died, several while still on board ship in the harbor. A cemetery was set up on the grounds for their interment and the graves were suitably marked. There is some indication that the well-meaning throngs milling about the grounds were responsible for a few deaths due to the injudicious plying of seriously ill patients with food, drink, and other delicacies. According to one eyewitness account "one poor fellow, quite sick but apparently recovering from a severe attack of typhoid fever, was laughing and chatting with his comrades, when he was suddenly convulsed and in a few minutes was dead. The physician and nurse were both surprised, and could account for it only on the supposition that he had eaten too much of some dainty, furnished with the best of intentions. A number of such sudden deaths have taken place. . . ."

In order to establish discipline about the area,

the Newport artillery, a local militia outfit, was assigned to guard duty, and a detail of sailors from the frigate *Constitution* helped in the erection of tents and in other ways. Surgeon Wheaton in due course instituted a system of passes, and visitors were no longer allowed to distribute gifts, everything now being given out by the Sanitary Commission, an organization somewhat analogous to the Red Cross. Clothing, linens and bedding in large quantities were donated by the people of Newport, but these were now utilized systematically in accordance with the needs of the hospital and patients.

Among the patients were some sixty or seventy Confederate prisoners. Complaints were numerous and loud to the effect that they had received favored treatment at the expense of "our boys." Visitors reported that they found prisoners wearing articles of clothing intended for Union sufferers and that said prisoners reacted with insolence and sometimes with utter vulgarity when this was called to their attention. Such conduct was most shocking to Victorian ears; but on the whole, the prisoners were a soft-spoken and gentlemanly lot. Their southern charm seems not to have been wasted, as "some well-dressed ladies conspicuously lavished their attentions upon the foes whose wounds had not in the least mitigated their enmity to the Government, or their determination to fight against loyal men." The same writer, however, was constrained to observe more objectively: "Some of the stories of these exclusive attentions to rebels were doubtless exaggerated."

While these stirring events were taking place, all was not austerity on Aquidneck Island. The *Newport Mercury* noted on July 19 that "the season [at Newport] has now fairly opened and a large number of visitors are enjoying our salubrious climate. The Hotels, with the exception of the Atlantic and Bellevue, which are closed, are doing a

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Lovell General Hospital, U.S.A., Portsmouth Grove, Rhode Island. View from Dyer's Island. Drawn from Nature & Lithographed by J. P. Newell, 1864. Printed by Endicott & Co., New York. Courtesy of Miss Alice Brayton.



good business and present the appearance that they have usually during the month of August. The number of cottages rented is one hundred and nine. . . ."

By the end of the month the hospital was functioning much more smoothly, and on the 30th Dr. Wheaton sent forward the following communication to Surgeon General Hammond:

U. S. Hospital  
Portsmouth Grove, R. I.  
July 30, 1862

Surgeon General  
W. A. Hammond  
U. S. Army

Sir

I have the honor to report that on my arrival from Washington to this Post, I found so many things requiring my personal attention, that I requested the Medical Gentlemen serving with me, to furnish a report of our voyage from Yorktown with the sick to this place, and all circumstances connected with our embarking at Yorktown and our debarkation after our arrival here, trusting their report, which you will please find inclosed, will meet your approbation.

I have the honor further to state, that I have this moment received an order from your office relieving me from duty at this Hospital, and to join my Regiment. Am I to await your orders to instruct me to whom I am to transfer the Government property now in my hands?

Very Respectfully,  
Your Obt. Servt.  
F. L. Wheaton

Dr. Wheaton was doubtless an ambiguous, controversial and unhappy figure. His devotion to duty and to his men is beyond question. Yet there is evidence that, even thirty-five years later, the acrimony surrounding him had not completely subsided. It would take an officer of superhuman qualities to carry out an operation of this magnitude without confusion. The unfamiliarity of the populace with the realities of modern warfare, and the lack of preparation for his arrival were important factors in the situation. There is reason to suspect, however, that his public relations were faulty, the local citizens failing consequently to comprehend either the enormity of his problem or the necessity for following sound military procedure.

Despite acid comments in newspapers and emotional letters to the editor, his conduct of affairs was defended vigorously by more experienced and cooler heads, including not only his professional and military colleagues, but the patients in the hospital as well. After a careful review of the affair, Bishop T. M. Clark stated: "I have made this statement of facts from the simple desire to do justice

where I am satisfied injustice has been done. . . ." Because of complaints which had reached New York, Dr. J. Oakley Vanderpool, surgeon general of the State of New York, was sent down by the governor of New York to look over the installation. In a letter to Dr. Wheaton, which was simultaneously released to the press, he stated: "Permit me to make a more formal expression, than the one made to you personally, upon the condition of the hospital. . . . Though but four days had elapsed since your arrival at the spot [letter dated July 11] with eighteen hundred sick and wounded, where not the slightest preparations had been made. . . . I found five streets of tents, every man comfortable in bed, all well fed, the regular duty of each medical officer and nurse assigned, and a degree of personal cleanliness creditable to the short period which had elapsed. . . . We should record and encourage the charitable and benevolent spirit of our people. At the first thrill of suffering, they press as one eagerly to aid by gifts and works in the amelioration of our able soldiers. Placed as you are, chief of so large a hospital, it is very trying, and at times difficult to control and not yet chill this charitable spirit. I am satisfied herein lies your chief cause of anxiety." He concluded: "I make this expression in no spirit of fulsome compliment . . . , but as simple justice to one occupying a most difficult and arduous position. . . ."

The official report prepared by his medical officers stated: "We feel it to be our duty to bear our united testimony to the fitness of Surgeon Wheaton for the direction of a Hospital of this magnitude. . . . With respect to the charges, which have been so maliciously and unjustly circulated, we desire to state that, to our positive knowledge, they are without foundation."

Dr. Wheaton, upon being relieved of duty at the hospital, returned to his regiment, the Second Rhode Island Volunteers, spending the remaining three years of the war in the general vicinity of Washington. He was mustered out of service at the close of the War, having attained the rank of Brigade Surgeon. He died in 1895 in his ninety-second year.

#### *Permanent Installation Built*

His replacement, Dr. D. J. McKibben of Philadelphia, whose stay was to be brief, arrived sometime during the ensuing two weeks. During this period the plans for a more permanent installation were initiated. These called for a total of fifty-eight structures including twenty-eight ward buildings. The wards were to be of one story, 160 feet long and 30 feet wide. Other structures eventually to be erected included mess hall, kitchen, bakery, laundry, drying rooms, several buildings for hospital quartermaster stores, dispensary, commissary department, officers' quarters, quarters for female



nurses, chapel, blacksmith and carpenter shops, stables, barracks for hospital guards, knapsack depository and morgue. In addition there were a post office, express office, "Cole's store" (a sort of post exchange), a bathhouse containing facilities for medicated baths, and even special diet kitchens. A steam plant provided hot running water to all areas and steam for the laundry and for cooking. The carpenter shop had a steam-driven circular saw, and there was a steam pump to provide water for extinguishing fires.

The grounds comprised about twelve acres running along the bay. Situated on a rise at about its mid-point was the former summer hotel which served as the administration building. On either side was a series of fourteen pavilions, each constituting a division of the hospital. A main avenue ran north and south from the central building with the individual wards placed obliquely on either side of it like feathers on an arrow. The wards were joined by a covered corridor, facilitating communication in the winter. All pavilions contained partitioned areas for bathroom, lavatory, and toilet at one end, and for wardmaster and nurse at the other. Each ward could accommodate fifty-six patients. Thus the hospital had a rated capacity of about 1,500 beds, but it could be expanded at will to 2,000 or more by the erection of tents. The budget ran to about fourteen hundred dollars a day, Civil War dollars.

Running water was provided by an interesting device. Springs at the top of the hill, seventy feet above the hospital, were dammed, forming a reservoir; the water was led in through iron pipe furnished by the Hope Iron Foundry.

Portsmouth Grove, located in the Town of Portsmouth, eight miles north of Newport, was on a pleasant bluff overlooking Narragansett Bay, an area now incorporated in the Melville Naval Reservation. The following contemporary description of the site as approached from the land gives some idea of its beauty: "Just back of us is a splendid group of majestic old elms, and below us a twinkling brook bordered with elder bushes in full bloom, with occasional wild roses peeping out from the grass. On our left, north and west of us, we see the two steamers landing sick and wounded cargo. Down the steep hill, through the valley, over a little bridge thrown across the brook and we soon arrive at a turning marked 'To the Portsmouth Grove House.' We turn obediently and keep turning to an apparently endless road, until at last we come in full view of the bay. . . ."

Along the shore adjacent to the hospital ran the tracks of the Old Colony and Newport Railroad. Quaint little trains drawn by puffing locomotives plied back and forth between Fall River and Newport. A wharf capable of discharging vessels of eight hundred tons had existed prior to the estab-

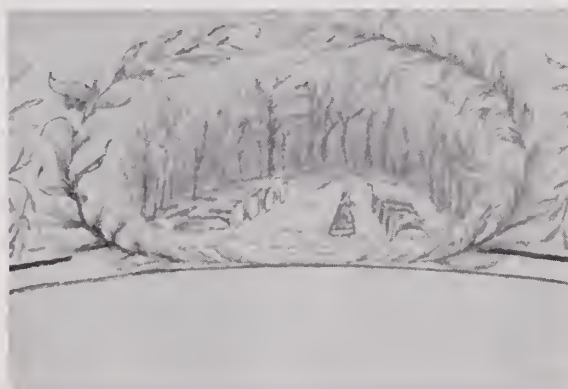
lishment of the hospital. This was found to be inadequate to berth the large military transports used to carry patients, but despite frequent recommendations that it be extended, the project was never carried out.

Dr. McKibben remained in charge for the balance of the summer. He was well liked and did a satisfying job of organizing the sizable institution. On August 17, the steamer *United States* sailed with 662 soldiers fit for duty. Previous discharges brought the number remaining to 800, but new and frequent arrivals from the front were to keep the hospital very active indeed. During the first week in September 1862, 1,204 fresh casualties were brought in and it was announced shortly thereafter that the census had reached 2,400, possibly an all-time high. At no time, however, was a hospital registration in excess of 1,000 unusual. During the first full year of operation (to August 1, 1863), 6,866 patients were received, 414 of these being Rhode Island men. There were in the same period 124 deaths, of which 101 were buried in the hospital cemetery.

*continued on next page*



U.S. General Hospital, Portsmouth, Rhode Island. Pen and ink sketch by J. Baker and J. M. Tabor, Jr. Courtesy of Newport Historical Society.



Detail from sketch (Figure II) by J. Baker and J. M. Tabor showing cemetery at Portsmouth Grove.

### *Surgeon Edwards Takes Command*

Early in September of 1862 Surgeon Lewis A. Edwards, a regular army officer holding the rank of major, was ordered to permanent command at the Grove, relieving Dr. McKibben. He came well recommended and proved to be a popular and efficient administrator. He was a fine-looking man, well-proportioned and over six feet tall. He had a stern, but pleasant manner, and commanded the respect of his men. His staff, which varied in number as personnel moved in and out, comprised on the average four assistant surgeons and nine acting assistant surgeons, the latter being civilian physicians under contract holding simulated rank. There were also a hospital steward, a chaplain and a quartermaster officer. The hospital guards were separately organized.

Shortly after Surgeon Edward's arrival, Miss Kate P. Wormely was appointed chief hospital nurse. She set to work immediately engaging her staff. The duties of female nurses were largely of a housekeeping nature. Miss Wormely had spent the early months of the War with the Sanitary Commission near Washington. In later years she gained eminence as a French scholar, based on her English translations of Balzac and Molière. One of her assistants, who was to become well-known locally, was Agnes Wilbour (Richardson) of Newport, who with her mother, Mrs. Mary Simmons Wilbour, were among the first to volunteer. Mrs. Richardson, who died in 1933 in her ninety-fourth year, had been in charge of hospital linens. She was reputed, at the time of her death, to be the last surviving Civil War nurse.

The Newport Artillery, which had served as hospital guard almost from the beginning, was relieved on September 29, and a letter of thanks was dispatched to its commanding officer. It was replaced by a chartered infantry company from Providence. The *Newport Mercury* reported: "Guard duty at Portsmouth Grove is not so pleasant as many suppose. . . . The Providence Infantry were compelled to draft the men, and of the sixty unfortunates, thirty-two procured substitutes by paying a premium. The pay is six dollars and fifty cents for fourteen days' duty, day and night. . . ." It should be noted, however, that some of those assigned were combat veterans who had been wounded in action. A permanent hospital guard was organized in the latter part of November and mustered into service on December 6.

One November 11, Miss Wormely sent an open letter to the *Newport Mercury* requesting foods and delicacies of all varieties and in large quantity to provide a Thanksgiving repast for her charges as attractive and sumptuous as the generosity of the good citizens could provide. The holiday was highly successful and the newspaper reported on Novem-

ber 29 that "after the men were fully satisfied with meats, the pies and cakes were served out, and a happier set of beings it would be difficult to find. . . ." The Naval Band was present and provided suitable divertissement.

The Chapel, which had been financed by the several churches of the state through popular subscription was dedicated on Christmas Day. The two-story building, with a library and reading room on the first floor, was to cost about \$1,400. At the time of its dedication about 800 books had been donated to the library, the number eventually growing to 1,600. The Chapel walls were decorated with shields inscribed with passages from the *Scriptures*, and it was equipped with a handsome melodeon. The auditorium could seat five hundred.

Toward the end of January 1863, the transport steamer *St. Marks* arrived with two cases of small-pox among its passengers. All of the patients from this ship were placed in a separate isolation ward. This move proved fortunate as some thirteen more cases appeared among those exposed. All of the other patients in the hospital were vaccinated, and Dr. Edwards requested that all persons refrain from visiting the hospital. No one was permitted to leave the grounds, and the Newport City Council passed and advertised an ordinance setting up a two-way quarantine between the city and the hospital. These measures were quite successful as it was noted on May 2 that "there are no malignant fevers at present, and the small-pox has disappeared."

Affairs in general were kept firmly in hand as indicated by the following brief vignette: "Our informant says he never saw so many at any previous time on crutches as there are at present. The men are perfectly contented with their treatment . . . and only long for their friends at home. Every department is kept in the most thorough state of cleanliness, and has the personal supervision of Dr. Edwards and Miss Wormeley, both of whom have the good will of the brave boys." The military touch was everywhere obvious as "the most perfect neatness is observed in beds, bedding, and in fact the whole establishment, from floor to ceiling." Nothing was too trivial to report in the papers and on one occasion the menu for a whole week was published. The food was obviously plain, but substantial and plentiful in typical army style.

### *Hospital Named Lovell General*

In a newspaper article dated May 16, 1863, the name Lovell was applied to the hospital for the first time. Its official name became "Lovell Hospital, Portsmouth Grove, R. I." It was also designated variously as Lovell U.S.A. Hospital; Lovell General Hospital, U.S.A., and U.S. General Hospital, Portsmouth Grove, R. I. It was named after Joseph



Lovell, surgeon general of the United States Army from 1818 to 1836, and first great organizer of the medical department.

The summer of 1863 found the country deeply involved in the war. Riots were occurring in New York City over the draft, although it had been accepted calmly in Rhode Island. Casualties continued to roll into the hospital. Yet these serious matters put no damper on the festivities at Newport: "The season is fast getting to its height and everything indicates one of prosperity. The number of visitors in the city is equal to that of last year which was considered the most successful of any previous one. Between six and seven thousand non-residents are passing the dog-days in our salubrious climate. . . . The Beach presents a lively appearance each morning as the hundreds of bathers in their varied costumes are gamboling in the surf. . . . We counted over three hundred vehicles on the Avenue Thursday afternoon, representing the wealth and aristocracy of all the larger cities in the loyal States. . . ." There were at that time some 235 general hospitals, caring for about 48,000 patients.

The inmates of the hospital kept themselves busy in various ways. Convalescents helped out in the kitchens, mess halls, laundry, carpentry shops and as teamsters. They spent their spare time playing checkers and cards, although, in accordance with hoary Army regulations, not for money. Patients were not permitted to receive liquor from visitors.\* Nearly all chewed tobacco, and spittoons were a necessary fixture in all wards. On one occasion a wardmaster gained the recognition of the Commanding Officer by requisitioning extra spittoons for his ward.

The patients seemed to derive pleasure from arranging little ceremonies. On one occasion a silver tea set was presented by them to one of the Acting Assistant Surgeons in appreciation of his services, and on the same occasion a silver pitcher and goblets to a wardmaster, and a gold watch to Nurse Agnes Wilbour, linen room mistress. At another time there was a formal flag raising accompanied by cheers and a thirteen gun salute. The flag, donated by the citizens of Newport, was unique in that it had the Rhode Island coat-of-arms on one side and a cock on the other, "the bird which was by the ancients sacrificed to Aesculapius, the God of Medicine [and it was inscribed], with the motto, 'dum spiro, spero (while I live, I hope).'"

\*There is a well-grounded tradition among the oldest inhabitants of Portsmouth, passed on to them by individuals then alive, that liquor (bootleg, no doubt) found its way into the inner sanctum in the following manner. An empty jug, along with money, was placed in the hollow trunk of a certain tree on the grounds. From time to time a local merchant, with whom prior arrangements had been made, replaced the empty jug with a full one.

Mr. Benjamin J. Tilley, proprietor of a newspaper store in Newport, deserves special mention in connection with the entertainment of the patients. He seems to have been a goodhearted and generous soul, and became a familiar figure about the hospital as he hobbled along on his crutches bringing words of good cheer and little gifts for the men. He kept the patients supplied with newspapers and periodicals and made his emporium the depot for various collections. On one occasion the following note appeared: "Mr. Benjamin Tilley acknowledges the receipt of many articles of clothing much needed for the comforts of the poor fellows. . . ." In November, 1864, he arranged for a Thanksgiving dinner for the soldiers and later for a liberal and successful one on Christmas. Probably his most ambitious undertaking was the Fourth of July celebration in 1865. "We who have been," said a newspaper notice, "kept comfortable by our brave soldiers for the last four years ought not to forget those at Lovell Hospital on the 4th of July. B. J. Tilley has it in hand. Help it by subscription, be it large or small." The eleven hundred men still on hand were entertained with an oration, appropriate ceremonies, fireworks in the evening, and, we presume, food.

At intervals, particularly during the holiday season, furloughs were granted to those well enough to travel. As is true in all wars, the enlisted men were chronically short of cash. This condition was aggravated by the tardiness of the paymaster in making his rounds, the arrears reaching at times the unreasonable sum of eight or ten months' pay. Money was solicited to help the men on their way, or on occasion they were carried free of charge on public conveyances through the kindness of transportation officials. Sometimes they were obliged to hire private vehicles and under such circumstances profiteering was not unknown. After one such experience the press reprimanded an unnamed individual for taking advantage of poor fellows "desir-

*continued on next page*





ous of visiting their homes after two years absence in fighting our battles."

Medical care at the hospital was probably of good quality relative to then current standards. There is no mention of operating facilities or of operations, but most of the surgery, which consisted of amputations and of removal of missiles, was performed in the forward areas. In a special report to Governor Sprague submitted in December, 1862, Dr. Lloyd Morton of Pawtucket had doubted the wisdom of establishing regional hospitals. Although his judgment was probably open to question, he made the following interesting observation: "This transfer [to installations near their homes] works to the peculiar disadvantage of one class of patients, *viz*: those who have suffered amputation of the leg or thigh. At St. Elizabeth's Hospital [in Washington], the Government has established the inventor of one of the most perfect artificial limbs, who is constantly employed (at the expense of the United States) in fitting limbs. . . . Why, then should this class of patients be deprived of this benefit by being removed, and in all probability discharged from the service, in some hospital remote from Washington?" Yet, prosthetic facilities were available at at least one other center, the hospital at Central Park, New York, two amputees of record having been referred there from Lovell Hospital. It is indeed noteworthy that medical authorities had conceived the idea of a special center eighty years before the beginning of World War II.

The monumental, but unfortunately little read, *Medical and Surgical History of the War of the Rebellion*, contains protocols of four cases that were treated at Lovell Hospital. The first was a gun shot (Minié ball) wound of the right thigh, penis and scrotum. The second was of a soldier admitted for treatment of an upper arm stump, following amputation in the field for a gun shot found near the shoulder. This patient was eventually transferred to Central Park for an artificial limb. The third report was of a patient who had suffered a wound of the ankle, resulting in a leg amputation. Delayed healing in both of the above cases was the chief problem, and "stimulating applications, including bromine" were utilized.\* The nature of the bromine preparation is not stated. The latter patient also was sent to Central Park for disposition.

The only mortality among the four reported cases was, oddly, not a battle casualty at all, but a hospital guard who had been in trouble because of an infraction of discipline:

\*According to Dr. J. Collins Warren (1842-1927) ". . . the use of fuming bromine [was] recommended by many surgeons in our Northern armies during the Civil War." From *To Work in the Vineyard of Surgery*, The Reminiscences of J. Collins Warren, ed. by Edward D. Churchill, M.D., Cambridge, Harvard University Press, 1958.

John H., aged 25, private in the Hospital Guards at Lovell Hospital, was confined four hours on the night of February 28, 1863, as a punishment for bringing spirits into camp and attempting to run the guard. When released from his cell by order of the officer of the guard, he rushed upon the latter and struck him in the face. The sergeant thereupon drew his sword, stepped back a pace and put himself on guard, holding the grip of his sword firmly against his right hip with the point slightly elevated. As the ground was uneven and covered with frost, the prisoner slipped, fell on the point of the sword, and then fell heavily forward on the ground. When picked up he was insensible and breathing heavily. After the blood, which had flowed copiously about his face, was washed away, only a slight wound in the right nostril could be found. The officer of the day, an acting assistant surgeon, was summoned immediately. He could detect no other injury than the trivial one to the right ala nasae.

The patient had been drinking heavily and it was felt, not unjustifiably, that he was merely drunk, whereupon he was returned to the guard house. The next morning, still unconscious, he was removed to a ward, where he expired thirty-one hours after injury.

An autopsy was performed some nine and a half hours post mortem. A transverse fracture of the posterior clinoid process was found. The specimen was forwarded to the recently organized Army Medical Museum.

In December of 1864, it was announced that Dr. Edwards, at his own request, had been relieved of duty at the hospital. He was replaced by Dr. Charles O'Leary, who commanded the installation until its closing. Dr. Edwards, who attained the rank of brevet colonel "for faithful and meritorious service during the war" and the permanent rank of lieutenant colonel in the regular army, died on November 8, 1877. On April 25, 1864, he was elected an honorary member of the Rhode Island Medical Society, bespeaking the high regard in which he was held by his colleagues in this area.

On August 19, 1865, it was announced that the hospital was to be broken up. All summer the paying off and mustering out of large numbers of patients had been going on slowly and laboriously. In the preceding two weeks some one hundred twenty-five patients had been discharged, leaving now only twenty-five. These were eventually transferred to a government hospital in Worcester, Massachusetts. Only two surgeons had been retained. The buildings and other public property were sold at public auction shortly thereafter and the land reverted to private hands. The hospital guards, consisting now of seventy men and three officers, all combat veterans, returned to Providence on August 28 to be

mustered out of service, bringing to an official close the hospital's activities.

During its four years of activity the hospital had been a very major operation indeed. No official statistics are available as to its total census, but it was announced on May 20, 1865 (Appomattox was on April 9) that the number of patients received had reached 10,490. So far as we can determine a subsequent detachment of 103 sick and wounded were the last to arrive, bringing the total to 10,593. Of these 308 died, while over 9,000 were returned to duty or discharged. The cemetery contained 251 bodies, while 57 had been removed by relatives or friends.

We can, I think, heartily agree, some ninety years later, with the following evaluation by a contemporary observer: "The proportion who had died is very small, if we consider the sad condition in which they were received . . . and it speaks well for the officers . . . as well as for the healthiness of the location."

The only remaining business after closing of the hospital was establishment of permanent care for the cemetery. It was reported in October 1865, that the Federal government had requested the state to assume this obligation. The grounds were reported to be in excellent order, the graves numbered, and a plain fence placed around the whole. A complete registry was maintained. Governor Smith proposed to ask the next General Assembly to pass the necessary legislation, but it appears unlikely that this was ever done. No such legislation is recorded and the cemetery is no longer in existence.

The following reminiscence, written in 1898 by D. C. Denham, once a ward-master in the hospital, gives an adequate explanation: "The War is ended and as I pass by on the Fall River Railroad (Old Colony) and the conductor calls out Portsmouth! what a flood of memories it brings to mind. Looking backward (33 years ago it was) as I look from the car window all I can see of Lovell General Hospital is the grounds and all that is familiar to me is the hill at the south part of the grounds. . . . Even the graves of the dead are gone, the bodies carried to that great National Cemetery at Arlington. . . ."

### *Acknowledgments*

The author wishes to express his sincere appreciation to all those who contributed to this endeavor, particularly to Mrs. Helen DeJong, librarian of The Rhode Island Medical Society, and to Mrs. Gladys Bolhouse, librarian of the Newport Historical Society, for their invaluable bibliographical assistance; to Miss Alice Brayton of Green Animals, Cory's Lane, Portsmouth, R. I., for reminiscences of her girlhood visits to neighboring Portsmouth Grove, and for use of the lithograph of Portsmouth Grove Hospital; to the late Miss Evelyn Chase, formerly president of the Portsmouth Historical Society, and director of public assistance of the Town of Portsmouth, for helpful advice, and particularly for the anecdote concerning the hollow tree used to convey fruit of the grain into hospital terri-

tory; to my faithful, patient and meticulous secretary, Miss Marie T. Clair; and to all those who assisted with suggestions and proofreading; including my long-suffering wife.

### I. SOURCES

- <sup>1</sup>Newport Mercury, 1862: July 12, 19, Aug. 16, 23, Sept. 6, 20, 27, Oct. 4, Nov. 15, 29, Dec. 20, 27. 1863: Jan. 10, 24, Feb. 14, Mar. 26, May 2, 16, 23, July 4, 11, 18, Aug. 8, Sept. 26, Oct. 10, Nov. 7, 21. 1864: Jan. 9, May 14, June 11, Aug. 6, 13, Nov. 12, 19, Dec. 24, 31. 1865: May 20, June 10, 24, July 1, 15, 22, Aug. 5, 26, Sept. 2, Oct. 14
- <sup>2</sup>Portsmouth Grove during the war. Lovell General Hospital as I Remember It, by D. C. Denham, Newport Mercury, Feb. 26, Mar. 5, 12, 19, 26, Apr. 2, 9, 1898
- <sup>3</sup>Newport Mercury, Aug. 8, 1908, Obituary, Kate Wormely
- <sup>4</sup>Newport Daily News, Nov. 10, 1864
- <sup>5</sup>Newport Herald, Nov. 21, 1929, 90th birthday, Agnes Wilbour Richardson
- <sup>6</sup>The Providence Journal, 1862: July 8, 10, 11, 31. 1865: May 17, Aug. 19
- <sup>7</sup>Statement to the press, by Bishop T. M. Clark, The Providence Journal, July 10, 1862
- <sup>8</sup>Report of inspection of the hospital at Portsmouth Grove, by J. Oakley Vanderpool, The Providence Journal, July 14, 1862
- <sup>9</sup>The Providence Journal, Nov. 20, 1932, 93rd birthday, Agnes Wilbour Richardson
- <sup>10</sup>The Providence Journal, Feb. 2, 1933, Obituary, Agnes Wilbour Richardson.
- <sup>11</sup>Boston Med. and Surg. J., 67:114, 1862, The Hospital at Portsmouth, R. I.
- <sup>12</sup>Communications of the Rhode Island Medical Society, vol. 1: Proceedings, p. 38, 1864. Annual Meeting of R. I. Med. Soc., June 1, 1864
- <sup>13</sup>Transactions of the Rhode Island Medical Society, 5:248, 1895, Obituary, Francis Levison Wheaton, M.D.
- <sup>14</sup>Report on the Physical Condition of the Rhode Island Regiments now in Field, etc., by Lloyd Morton, Providence, Alfred Anthony, Printer to the State, 1863
- <sup>15</sup>Town Records, Office of Town Clerk, Portsmouth, R. I., Land Evidence Book No. 14, Aug. 5, 1865
- <sup>16</sup>Original Documents Pertaining to Establishment of Hospital at Portsmouth Grove. From the National Archives and Records Service, Washington, D. C. Photostatic copies deposited in R. I. Med. Soc. Library: a. W. A. Hammond, Surg. Gen., U.S.A. to Surg. C. S. Tripler, U.S.A., Med. Director, Hq. 2nd Army of Potomac, June 8, 1862. b. W. A. Hammond, Surg. Gen., U.S.A. to Genl. M. C. Meigs, Qm. Gen., U.S.A., June 8, 1862. c. F. L. Wheaton, 2nd R. I. Vol. Transmits report of voyage from Yorktown to Portsmouth Grove with sick. Acknowledges receipt of order to join his regiment, July 30, 1862. d. Report relative to the removal of sick and wounded from Yorktown to Portsmouth Grove, R. I., under the charge of Surgeon F. L. Wheaton, July 31, 1862.
- <sup>17</sup>Personal communications from National Archives and Records Service, Washington 25, D. C., to Mrs. David C. DeJong, Librarian, R. I. Med. Soc. Library, enumerating available documents. Deposited in R. I. Med. Soc. Library

### II. REFERENCES

- <sup>1</sup>Letterman, Jonathan: Recollections of the Army of the Potomac, New York, D. Appleton and Co., 1866
- <sup>2</sup>McClellan, George B., Maj. Gen., U.S.A.: Report on the Organization and Campaigns of the Army of the Potomac, New York, Sheldon & Co., 1864
- <sup>3</sup>Powell, William H.: List of Officers of the Army of the United States from 1779 to 1900, New York, Hammersly and Co., 1900

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# The RHODE ISLAND MEDICAL JOURNAL

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## MR. REUTHER, LABOR HEALTH DEMANDS, and the BLUE PLANS

AT THE 17th constitutional convention of the United Auto Workers, held in Atlantic City last month, Mr. Walter Reuther, president of the union, presented his report which covered problems ranging from the details of contract negotiations to union participation in world affairs — a report that was subsequently published as a thirty-two-page magazine of tabloid newspaper size.

On the subject of health security for his workers, Mr. Reuther, bemoaning the failure of Congress and the public to embrace former President Truman's 1948 proposals for a national compulsory health insurance system, indicted the voluntary Blue Plans and commercial insurance programs. He generalizes, as is the way of politicians also, with statements such as the following: "But years of experience have demonstrated built-in inefficiencies, waste, increasing costs and an utter lack of responsiveness to consumer needs in prevailing health insurance and medical practice."

His generalization made, he proceeds to report that his union has now sponsored the development of the Community Health Association, a comprehensive prepayment medical care plan soon to be launched in the Detroit area. It will provide complete medical care on a prepayment basis furnished by physicians working in groups and based in community hospitals, and he expresses the confident hope "that this experimental program will demonstrate in very practical fashion the social, economic and medical advantages of group practice prepay-

ment plans."

"The modest and reasonable goals" for which Mr. Reuther says his union is "prepared to pay whatever reasonable cost is needed to achieve them" consist of:

1. Fully prepaid medical care unencumbered at the time of receipt of health services by economic deterrents such as deductibles — similar to deductible provisions in automobile insurance — and coinsurance.
2. Comprehensive protection for necessary health services whether performed in the hospital, home or doctor's office, and whether for treatment of illness or injury or for preventive care, diagnosis or rehabilitation.
3. Economically and efficiently organized services in medical facilities offering ready access to the full range of medical skills and specialties.
4. High standards of quality achieved by systematic and continuous review of medical practice by qualified medical authorities.

In simpler terms, it would appear that Mr. Reuther proposes a comprehensive hospital-surgical-medical care program as opposed to the Blue Plans which necessarily limit their coverages in order to take care of catastrophic illnesses mainly, and at the same time provide a premium charge within the range of the great majority of the public.

What is the "reasonable cost" that Mr. Reuther would pay for his comprehensive coverage? Sig-



nificantly, his contracts with the auto industry require industry to pay HALF the cost of the Michigan Blue Plans for not only the coverage for the worker *but also for his FAMILY*. He is also a strong proponent of national compulsory health insurance, and he would undoubtedly yield his Community Health Association on short notice to a federal program.

Mr. Reuther has a peculiar ability to define terms to suit his thinking of the moment, as was evidenced in his testimony before the House Ways and Means Committee last July. Undoubtedly his definition of "reasonable cost" could be cast to meet any given situation, confusing as the definition might be to a student of economics.

Mr. Reuther, as a Michigan resident, is well aware of the work of the Michigan Blue Plans. His leadership was effective in developing the programs in that state, and if they have "built-in inefficiencies" and waste then he should have been in the forefront with evidence and with solutions.

As a nonprofit organization the Michigan Blue Shield is under the purview of the insurance department as well as the general public. The fate of the Michigan program in recent years parallels that of similar voluntary insurance plans in other states. Inflation has devaluated our money at a time when a majority enrollment in the insurance plans has increased the utilization of hospital and allied medical services.

In 1958 the Michigan Blue Shield Plan sustained a loss of \$2,998,274. That loss was from a reserve fund, and it was paid out for subscriber benefits under a plan far more restrictive than Mr. Reuther anticipates for his Community Health Association.

Mr. Reuther maintained to the Congressional committee that "any law in a free society should make benefits available to every citizen who needs the benefits and who is willing to pay the cost of such benefits." But he considers the costs of the nonprofit Blue Plans unfavorably and he criticizes in the same breath the failure of the Plans to give even more liberal coverages.

Who will be willing to pay Mr. Reuther's "reasonable costs" which are yet to be defined? The worker? or will industry, already bearing half the tax charge as employee compensation, be bargained with for additional money to meet the "reasonable costs" which it will in turn pass along to the rest of the country in increased auto prices? Is it thus that Mr. Reuther will prove his theory that his union can run a better and more liberal health care program than the voluntary nonprofit Plans?

### QUACKERY ON TELEVISION

Recent press reports concerning the rigging of quiz programs on television indicate that the television industry has had some misgivings about these rather unsavory disclosures. A spokesman for the

industry has stated that outside packaging producers "have hoodwinked the public and broadcasters whose facilities they use." He further stated that the industry "has proved, in its four decades of service, it can clean its own house when necessary." This claim apparently does not extend to its function as an advertising medium.

There is certainly no evidence that it has made any attempt to control in any effective fashion the outpouring of tawdry and misleading advertising by the patent medicine industry. The spate of hard-sell goes on unabated. There are products for "tired blood," to quench burning fires in the stomach, and to still the hammers that pound and the lightning that flashes inside the cranium. Diagrams show drugs that go 'round and 'round and come out here. Actors do before-and-after stunts which show startling restoration of vitality. Mother's aching back responds to the balm with spectacular relief. Take one pill to go to sleep, and another to stay awake. Never fear, and never see your doctor.

As we have pointed out in a prior issue [April 1959] the danger in this type of promotion lies not only in wasting money on improper, ineffective, or completely inert medication, but more seriously in postponing treatment where there may be serious disease. We might add, incidentally, that there has been no improvement in this regard in the local press. Not everything published herein is thus ignored.

### THE SOCIETY REPORTS ON THE AGED

The report of the Society's Committee on Medical Economics, in which the problems of medical care for the older age population of the state are extensively reviewed, is published in this issue of the Journal. Every member of the Society should carefully read this report which the House of Delegates approved last month.

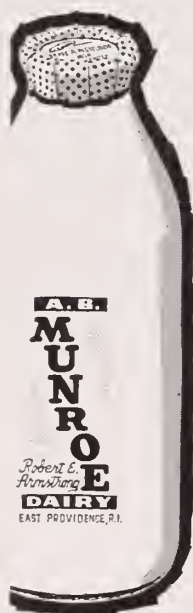
The efforts of politicians and social planners to capitalize the increasing segment of the population over the age of 65 years has created a sizable furor about the medical care of these people, as if that were the main and only problem with which they are faced. The Society's review of the issue does much to indicate that in Rhode Island at least, the physicians' role in the medical program for the older age group far surpasses in importance any efforts by other groups of individuals, or agencies, in our community.

The Society has faced up to its part of the problem, and it has clearly indicated both its ability to cope with its task, and its willingness to explore every feasible method to lessen the cost of medical care for the person with limited resources, whatever his age.

We need most at this time strong support from our elected leaders at the national, state and local levels to combat the inflation of the dollar which

*concluded on next page*

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seriously affects the earning and spending economy of each of us, and which particularly robs the aged or retired worker at the time when he is in greatest need for full value on his savings or insurance investments.

Merely to rush to Washington and dip into the federal cash bags for funds to create a system of care for the aged is no solution. On the contrary, it would add chaos to the very situation it seeks to improve.

As the Society's report aptly states — "every agency and citizen should be urged to contribute positive and constructive thinking for a solution to this and other health care problems at local levels and without federal intervention and subsidy that could lead to further socialization and yielding of personal liberties."

## THE HOSPITAL AT PORTSMOUTH GROVE

*concluded from page 743*

- <sup>4</sup>Stone, Edwin W.: Rhode Island in the Rebellion, Providence, George H. Whitney, 1864
  - <sup>5</sup>Thomas, Benjamin P.: Abraham Lincoln, New York, Alfred A. Knopf, 1952
  - <sup>6</sup>Williams, Harry T.: Lincoln and his Generals, New York, Alfred A. Knopf, 1952
  - <sup>7</sup>Williams, Kenneth P.: Lincoln Finds a General, 4 vols., vol. 1, New York, The Macmillan Co., 1949
  - <sup>8</sup>Wilson, Joe Harvey: Soldier relief work in Rhode Island during the Civil War, Brown University, M. A. Thesis, 1931
  - <sup>9</sup>The Columbia Encyclopedia, 2nd Edition, Peninsula Campaign, p. 1509, Seven Days Battle, p. 1797, New York, Columbia University Press, 1950
  - <sup>10</sup>The Photographic History of the Civil War in Ten Volumes, Ed. by Francis Trevelyan Miller, Vol. I, The Opening Battles, New York, The Review of Reviews Co., 1912
  - <sup>11</sup>Dictionary of American Biography, re: Kate P. Wormely, vol. XX, p. 534, New York, Charles Scribner's Sons, 1936
  - <sup>12</sup>Medical and Surgical History of the War of the Rebellion. Prepared under the direction of Surg. Gen., U.S.A. Parts I, II and III, 2 vols. each, Washington, Government Printing Office, 1875-1888
- Case Reports: Part I, vol. 11, p. 33; Part II, vol. II, p. 373, 698; Part III, vol. II, p. 538

## LEFT HEART PUNCTURE IN ASSESSMENT OF MITRAL AND AORTIC VALVE DISEASE

*concluded from page 732*

- <sup>5</sup>Smith, P. W.; Wilson, C. W.; Cregg, H. A., and Klassen, K. P.: Cardioangiography. J. Thoracic Surg., 28:273, 1954
- <sup>6</sup>Brock, R.; Milstein, B. B.; Ross, D. N.: Percutaneous left ventricular puncture in the assessment of aortic stenosis. Thorax 11:163, 1956
- <sup>7</sup>Lehman, J. S.; Musser, B. G.; Lykens, H. D.: Cardiac ventriculography. Am. J. Roentg. 77:207, 1957
- <sup>8</sup>Radner, Stig: Extended suprasternal puncture technique. Acta Medica Scandinavica, 151:223, 1955

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## MEDICAL CARE FOR THE OLDER AGE POPULATION IN RHODE ISLAND

A Special Report by the Committee on Medical Economics of the Rhode Island Medical Society Approved by the House of Delegates of the Society on October 7, 1959

### SUMMARY

THE EVIDENCE that older aged persons seek and receive medical care in Rhode Island, and pay for the services in full or in part, according to their means, indicates both an appreciation of the importance of our elders in maintaining good health, and at the same time a fine co-operation between the physicians and health agencies in our communities in providing medical services at reasonable cost.

Current fees charged for home and office visits by physicians are fair and reasonable by all accepted standards. Even the state Department of Social Welfare has taken cognizance of the reasonableness of the fees charged for professional medical services. Certainly no other group of individuals in our state has voluntarily come forward with a comparable contribution to the solution of the economic problem of the entire population, and particularly the older age group, as has the medical profession through its service feature of the Physicians Service insurance program.

The recommendation is advanced that the Society urge industrial concerns in Rhode Island to give favorable consideration to the hospital-surgical-medical insurance coverage, both regular and catastrophic, for employees which could continue after retirement of the worker.

The recommendation is also advanced that a permanent liaison committee be established composed of hospital administrators, hospital trustees, Blue Cross, Physicians Service and Rhode Island Medical Society representatives, that would meet regularly and maintain a lively interest in hospital costs, exploring every possible way in which they may be kept at a minimum, with particular attention to unnecessary hospitalization, the avoidance of duplication of pre-hospital services or laboratory tests and payment of pre-hospital diagnostic and laboratory procedures when followed by hospitalization, thus cutting down the duration and expense of the hospital stay.

A recommendation is made that the Rhode Island Medical Society direct an appeal to the insurance industry, through its trade associations and to the companies directly, if possible, urging that they eliminate the age requirement from their health and accident insurance coverages.

The Committee feels that every effort should be made to bring forcefully to the attention of the public in general, and to public agencies, including press, radio, and television in particular, the continuing efforts in Rhode Island to provide voluntary prepaid health care for all citizens, and particularly the older age group.

Your Committee believes that outstanding progress has been made in Rhode Island to assist the over age 65 person to meet his medical care costs, and that every agency and citizen should be urged to contribute positive and constructive thinking for a solution to this and other health care problems at local levels and without federal intervention and subsidy that could lead to further socialization and yielding of personal liberties.

### *Committee on Medical Economics*

STANLEY D. SIMON, M.D., *Chairman*

JOHN F. W. GILMAN, M.D.	SAUL WITTES, M.D.
CHARLES L. FARRELL, M.D.	GUSTAVO MOTTA, M.D.
JOSEPH WITTIG, M.D.	MICHAEL G. PIERIK, M.D.
EDWARD ZAMIL, M.D.	ARTHUR E. HARDY, M.D.
JAMES MCGRATH, M.D.	ALFRED L. POTTER, M.D.

In order properly to consider additional methods at local levels to assist the older age persons in Rhode Island with their medical expenses, consideration must first be given to the present health status of this segment of the population. The most recent available study is that made in 1953 by the Governor's Commission to study problems of the aged. The data on the physical health of the over age 65 persons stemming from that study presumably holds true for that age group today.

The Study Commission reported that—

- 1) Two thirds of the aged were well. (65% said that they were in fairly good health).
- 2) More than half (54%) were in good health and had no serious physical defects. In this category were found: 65% of the men and 59% of the women aged 65 to 69; 51% of the men and 53% of the women aged 70 to 74 years; 52% of the men and 41% of the women who are 75 years and over.
- 3) One fourth (27%) of the aged were handicapped by serious defects of vision, hearing, or mobility.
- 4) Of the 46% of the aged who reported them-

selves as being in poor health, 14% listed themselves entirely limited in physical activity. They are bedridden or chair bound, and they represent 6% of the total aged population, exclusive of the aged hospitalized in state institutions. (As of June 1, 1959 there were 1,890 persons over the age 65 in the state institutions. See Table I.)

5) Among 25,000 persons who reported poor health conditions, apart from physical handicaps, 43% said they were suffering from some form of cardiovascular disease. Arthritis was reported next in prevalence, affecting from 14 to 25%. Other frequently reported conditions were diabetes, kidney trouble, cancer, and general deterioration.

(For the purposes of the survey, reports of heart trouble, high blood pressure, hypertension, shock, hardening of the arteries, circulatory ailments, etc.—not mutually exclusive terms and admittedly not precise—were recorded in the category of cardiovascular disease.)

6) Better than two thirds (71%) of the aged reported that they had received medical services of one type or another during the previous year, and of this number 88% consulted a doctor one or more times, 13% were hospitalized, and 5% had nursing care at home. In the total aged population, 63% (45,000 persons) consulted a physician during the year, and 9.5% (6,800 persons) were hospitalized.

7) Among the aged who received medical care during the year, 80% (40,000 persons) reported that they paid for these services themselves, either in part or in full. (This estimate uses the term medical care as all-inclusive of physician services, hospital expense, drugs and medicine, home nursing care, and appliances.)

Another 10% reported their medical expenses paid by Blue Cross or other insurance. About 8% received medical services which were paid for through the Old Age Assistance program. One in ten had some help from relatives.

(As the Commission noted in its report, "there is no doubt that medical and hospital rates were adjusted to the means of aged persons receiving services, as they are for the population generally.")

Persons interviewed in the Commission's survey were asked: "Except for minor temporary ailments, such as a cold, would you say you are now in fairly good health?" Those who answered negatively were asked: "What is your main trouble?"

All were asked, "Do you have physical handicaps such as poor eyesight, poor hearing, or trouble getting around?" Finally, persons saying they were ill or physically handicapped were asked, "How much are your daily activities limited by your condition?"

The Commission recognized that answers to these questions did not provide a basis for evaluating health conditions of the aged in any strict sense, as any physician would readily point out. However,

the answers did give a clue to the attitude of the aged themselves as to their health and physical condition.

Several valid assumptions appear reasonable from this data.

As noted by the Commission, "one may be gratified that nearly three out of four in the total aged population are free of serious physical defects, (and) more than half (54 per cent) are in fair health and have no physical disability."

The evidence that old age persons seek and receive medical care in Rhode Island, and pay for the services in full or in part, according to their means, indicates both an appreciation of the importance of our elders in maintaining good health, and at the same time a fine co-operation between the physicians and health agencies in our communities in providing the medical services at reasonable cost.

The reports from those complaining of poor health indicate disabilities of a chronic disease nature, many of which can be alleviated with treatment, but few of which can be completely eliminated. Home and nursing care, adequate housing and proper diet, plus leisure time activities to keep the older age person occupied, offer a major challenge in the face of a chronic illness.

TABLE I  
Estimated Number of Aged Persons  
in Rhode Island State Institutions  
(As of June 1, 1959)

	<i>Estimated No. aged 65 and over</i>	<i>Population ending 6/1/59</i>	
State Hospital	1,140 (6/58)	3,409	33.4%
State Infirmary	500 (10/58)	597	83.8%
Ladd School	30 (7/59)	909	3.3%
Zambarano Mem. Hosp.	80 (7/59)	303	26.4%
Adult Correctional	15 (7/59)	521	2.9%
Veterans' Home	125 (2/59)	218	57.3%
	1,890	5,957	31.7%

In round numbers you may remember this finding of 1,890 out of 5,957 by saying about 1 of every 3 of the some 6,000 in these institutions are 65 or over. You will note the great range involved too. Thus as would be expected our Adult Correctional Institutions has a small aged population (2.9%) as compared to our State Infirmary—our geriatric institution—which had 83.8% of its population in the 65 and over age group. You will note that the dates vary in terms of the time the data was available for the various institutions. However, for our purposes this is relatively unimportant.

Source: Department of Social Welfare, State of Rhode Island.

The survey indicated that in 1952 about ten per cent reported their medical expenses paid by Blue Cross or other insurance. In the intervening years Blue Cross has enrolled 70% of the people in the state who are over the age 65, and Physicians Serv-

*continued on next page*



ice has enrolled 50% of this group. In addition there has been a tremendous development of insurance coverage for persons over the age 65 by private insurance companies in the health and accident field.

In the intervening years the Department of Social Welfare has established its "pooled fund" whereby complete medical care is given under its public assistance program. An impartial study of the Department released in January, 1959, indicated clearly that of all groups in the state the medical profession is making the greatest contribution to aid all persons, and in particular to those receiving old age assistance, by rendering services at relatively low rates, or for no charge whatever. (See Tables II and III.)

### *Implementation of Report Made to the House of Delegates*

Your committee has held two lengthy meetings at which reports and studies by subcommittees have been considered and evaluated. In accordance with the mandate of the House of Delegates, the Committee makes the following comment on the suggestions set forth in the report adopted by the House at the April Session and referred to the Committee on Medical Economics for study and suggestions for implementation.

TABLE II

#### *Free Services to Public Assistance Recipients (Exclusive of GPA) in Rhode Island During 1956-57*

It is clear that the quantitative standards and the fee schedules in effect are not unduly liberal. The Office of Medical Services appears to have been successful in securing the co-operation of the profession in the development of reasonable standards. The Director of Medical Services points out, too, that in addition to providing services at relatively low rates, under the regular program, many physicians give medical care for which no bills are presented. Also, they continue to render free services at hospitals which benefit the recipients of public assistance. In another connection the Director enumerated these free services to public assistance recipients (exclusive of GPA) in Rhode Island during the year 1956-57 as follows:

<i>Services</i>	<i>Reasonable Fees</i>	<i>Total Value</i>
46,000 hospital visits at .....	\$ 5.00	\$230,000
887 surgical .....	130.00	133,000
275 tonsils and adenoids .....	65.00	17,875
130 deliveries .....	130.00	50,570
42 D. & C. .....	62.00	2,604
29,350 O.P.D. services .....	3.00	88,050
Total free services to PA recipients		\$522,099

*Source:* Report of Special Commission to Appraise the Financial operations of the state Government and the Matter of State-Local Financial Relations. January, 1959.

### *Resolution I*

#### *Home and Office Fees for Older Age Persons*

Your committee has noted that the current fees charged for home and office visits by physicians are fair and reasonable by all accepted standards. Even the state Department of Social Welfare has taken cognizance of the reasonableness of the fees charged for professional visits, as noted previously in this report.

As revealed in the survey of the aged made several years ago, physicians' charges are obviously in no manner a burden for the aged in this state. Our doctors have always adjusted their fees for elderly persons retired from work, or for those who live on a limited income, and we have every reason to believe that our membership will continue to give individual consideration to a patient of any age, and particularly to an older age person, in the matter of adjusting a fee that might constitute a financial hardship.

In view of the study commission's observation that "impaired vision has the highest incidence of disability," it is worthy of comment that in its review of the reasonableness of medical charges a survey report of the state social welfare department states that "the average charge for a complete eye examination, the fitting of glasses, together with lenses and frame, was \$13.

TABLE III

#### *Comparison of Monthly Payments for Medical Care, Through Pooled Fund or Otherwise, New England States, August, 1958*

<i>State</i>	<i>OAA</i>	<i>ADC</i>	<i>AB</i>	<i>AD</i>
Connecticut .....	\$20.00	\$6.09	\$16.00	\$35.00
Maine .....	7.50	.86	6.00	12.00
Massachusetts .....	19.77	3.32	1.50	33.53
New Hampshire .....	15.00	3.98	11.00	30.00
Rhode Island .....	11.00	4.38	6.00	14.00

It appears from this tabulation that expenditures for medical care in Rhode Island are decidedly reasonable compared with those in neighboring states. The director of Medical Services is convinced that the services rendered are fully as good as in other states. The relatively low expenditures he attributes to close co-operation with the professional societies which has enabled him to set standards and fees which are extremely reasonable, and to the careful supervision of the program. This supervision assures the large majority of practitioners who are willing to co-operate that the standards will be applied in all cases for the benefit of the community, and is largely responsible for the continuing support of the program by the professional groups.

*Source:* Report of the Special Commission to Appraise the Financial Operations of the State Government and the Matter of State-Local Financial Relations. January, 1959.



The enrollment of the older age population under the Physicians Service program — the highest by any such voluntary program in the nation — has proved anew the desire of the elderly to provide for their own health care costs, and at the same time it indicates an appreciation of the unique contribution by the doctors of Rhode Island whereby they guarantee the surgical procedure costs for persons of specified income classifications within which the great majority of retired and elderly persons undoubtedly are listed.

Under this insurance coverage, now held by more than 50% of the state's over age 65 group, the fee for the surgeon, the assistant surgeon, and the anesthesiologist is guaranteed. *No other group of individuals in our state has voluntarily come forward with a comparable contribution to the solution of the economic problem of the entire population, and particularly the older age group.*

### **Resolution II**

#### ***Continuance of Blue Cross, and Physicians Service, and Private Insurance Company Coverage Upon Retirement***

As noted previously, Blue Cross and Physicians Service in Rhode Island have for many years opened their direct enrollment campaign to persons of any age, and they have also allowed employed persons to continue their coverages in the Plans upon retirement. Earlier this year the executive director of the Plans, in a public announcement, reported that of the more than 70,000 people in the state who are over age 65, approximately 56,500 are enrolled in Blue Cross, and 41,000 are enrolled in Physicians Service.

At that time, he reported, Blue Cross had 400, and Physicians Service 300 subscribers between the ages of 90 and 99, and there were more than 5,000 in Blue Cross and nearly 4,000 in Physicians Service between the ages of 80 and 89. Benefits for these persons were not reduced in any manner because of the age of the subscriber.

Many business concerns in Rhode Island have made the continuance of Blue Cross-Physicians Service benefits part of an employee retirement program.

A recent survey of the insurance industry also indicates that a very large majority of insurance companies writing group insurance make available policies in which benefits are continued when the worker retires. Thus, at the present time this survey indicates that 51.9% of the people insured under group hospital programs have some measure of protection at the time of retirement, either through a continuance of the plan under the retirement program, or by conversion to an individual policy. In other words, half the people insured by group hospital plans of insurance companies have this protection available to them when they retire.

The survey also indicates that 31.6% of employees and dependents covered under group surgical plans written by insurance companies will have the coverage continued after retirement, and 34.7% the regular medical.

Major medical coverage is moving in the same direction. The same survey reveals that 19.4% covered under supplementary major medical coverage, and 46.4% of people covered under comprehensive major medical policies, will have such coverage continued after retirement. This is an impressive statistic inasmuch as it reveals that one out of two persons insured under group comprehensive major medical insurance will retain such coverage after retirement.

On an individual basis for major medical insurance there are at this time three companies that will issue policies after the age 65, and there are twenty companies that will renew a major medical insurance policy for life if the insured has purchased the policy prior to age 65. It is significant too, that one third of the people covered by major medical policies have contracts which are guaranteed renewable, and they will not be canceled for reason of health deterioration.

To your Committee these statistics revealing action by the insurance industry are extremely significant in that the vast majority of these programs have come about in the last five years.

Your committee recommends that the Society urge industrial concerns in Rhode Island to give favorable consideration to the hospital-surgical-medical insurance coverage, both regular and catastrophic, for employees which would continue after retirement of the worker.

### **Resolution III**

#### ***Special Hospital Insurance for the Elderly***

Your committee recognizes that the problem of hospital charges is entirely outside the jurisdiction of the medical profession. We feel that the public generally does not realize that doctors are in no way responsible for the fees charged by hospitals, and that they do not sit on the governing boards that resolve the economic issues of the hospitals. We will not attempt to report or analyze the many factors that are affecting the community's hospital bill today. The hospital cost is being increasingly underwritten through prepaid insurance. There is need for more general public education for better understanding of the economic factors that will continue to affect both the cost of hospitalization as well as the premium charges of the voluntary plans to meet that cost.

Doctor Francis B. Sargent, in his presidential address to the Society in June, pointed out that "seventy-one per cent of the hospital's expense is for wages for employees." In view of the inflation-

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ary era in which we currently find ourselves it is self-evident that the wage factor is a continuing vital one in the over-all cost of running a modern hospital.

Again, we are mindful of the new techniques in medical and surgical care involving hospital services, the great change in the public's conception of the use of the hospital, a change which, together with a rise in population, has resulted in a 50% increase since 1950 in the number of beds in the general hospitals in Rhode Island.

Whether a special hospital insurance coverage specifically for the elderly person at a reduced or special rate, as suggested in the House report, is feasible or possible is doubtful.

We do believe, however, that a permanent liaison committee that would meet regularly and maintain an active interest in hospital expenses should be established, composed of hospital administrators, hospital trustees, and Blue Cross, Physicians Service, and Rhode Island Medical Society representatives to explore every possible way in which hospital costs may be kept at a minimum, and duplication of hospital services or laboratory tests completed prior to admission might be avoided.

#### *Resolution IV*

##### *Elimination of Insurance Company Cancellations Because of Age*

As noted above, the insurance industry has made rapid strides in opening up its coverages to older age persons, making both regular and major medical contracts guaranteed renewable and not to be canceled because of health deterioration. Likewise, the companies have made advances in removing the age barrier for renewal of coverages.

A check of a statistical reference of the companies writing life and accident and sickness insurance indicates that 40 out of the 100 companies listed have no set age limit such as has been the practice previously, and of this group 12 list lifetime renewal coverage. This trend is most encouraging.

An estimate of current health and accident coverage for persons over age 65 sets a figure of 2,500,000 with coverage provided by insurance companies, 3,500,000 with Blue Cross-Blue Shield, and 400,000 covered under independent plans.

Your Committee recommends that the Society direct an appeal to the insurance industry, through its trade associations and to the companies directly, urging that they eliminate the age requirement from their health and accident insurance coverages.

#### *Resolution V*

##### *Public Co-operation for Comprehensive Health Plans*

Your Committee feels that every effort should be made to bring forcefully to the attention of the public in general, and to public agencies, including the press, radio, and television in particular, the efforts in Rhode Island to provide voluntary prepaid health care for all citizens, and particularly the older age group.

In August of this year the Health Insurance Institute reported the number of persons in Rhode Island with health insurance increased by 5,000 last year to reach a total of 706,000 at the end of 1958. Thus, it reported, some 83.1% of the state's estimated current population now have some form of health insurance designed to help pay hospital and doctor bills. This survey, based on reports of insurance programs of insurance companies, Blue Cross-Physicians Service and other health care plans, also indicated that the number of persons with surgical expense insurance is an estimated 597,000, and persons protected by regular medical expense insurance, providing for doctor visits for non-surgical care, increased to a total of 556,000 by the end of 1958.

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*References:* 1. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Bonica, J. J.: in Drugs of Choice, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in Current Therapy, Saunders, Phila., 1958, p.78. 6. Bickerman, H. A.: in Drugs of Choice, Mosby, St. Louis, 1958, p.547.

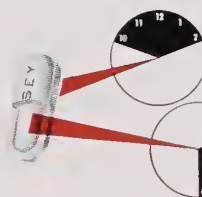
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# HOUSE OF DELEGATES

## *of the*

### RHODE ISLAND MEDICAL SOCIETY

Report of Meeting Held October 7, 1959

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library in Providence on Wednesday, October 7, 1959. The meeting was called to order by the president, Doctor Alfred L. Potter, at 8:00 P.M. The following delegates were in attendance:

**BRISTOL COUNTY:** Robert W. Drew, M.D.  
**KENT COUNTY:** Peter C. Erinakes, M.D.; Donald K. O'Hanian, M.D.  
**NEWPORT COUNTY:** Anthony T. Carrellas, M.D.; Philomen P. Ciarla, M.D.  
**PAWTUCKET DISTRICT:** Robert C. Hayes, M.D.; Alexander Jaworski, M.D.; Harry Hecker, M.D.  
**WASHINGTON COUNTY:** James McGrath, M.D.; Samuel Farago, M.D.  
**HOONSOCKET DISTRICT:** Joseph A. Bliss, M.D.  
**OFFICERS OF THE RIMS** (other than delegates): Alfred L. Potter, M.D. (president); Earl J. Mara, M.D. (president elect); Arthur E. Hardy, M.D. (secretary).  
**IMMEDIATE PAST PRESIDENT OF RIMS:** Francis B. Sargent, M.D.  
**PROVIDENCE MEDICAL ASSOCIATION:** Irving A. Beck, M.D.; Alex M. Burgess, Jr., M.D.; Bertram H. Buxton, Jr., M.D.; Wilfred I. Carney, M.D.; Francis H. Chafee, M.D.; Michael DiMaio, M.D.; Henry B. Fletcher, M.D.; Frank Fratanuono, M.D.; J. Merrill Gibson, M.D.; John F. W. Gilman, M.D.; Seebert J. Goldowsky, M.D.; John C. Ham, M.D.; Walter S. Jones, M.D.; Joseph G. McWilliams, M.D.; William S. Nerone, M.D.; Francis W. Nevitt, M.D.; Arnold Porter, M.D.; William A. Reid, M.D.; Ralph D. Richardson, M.D.; Stanley D. Simon, M.D.

Delegates without voting power present were Jeremiah A. Dailey, M.D., State Health Department director, and Charles J. Ashworth, M.D., delegate to the A.M.A.

Also present was Charles L. Farrell, M.D., secretary of the Rhode Island Medical Society Physicians Service and John E. Farrell, Sc.D., executive secretary.

#### *Report of the Secretary*

Doctor Arthur E. Hardy, secretary, noted that his report had been submitted to the delegates in the handbook. There was no discussion of the report.

*Action:* It was moved that the report of the secre-

tary as submitted be approved and placed on file. The motion was seconded and adopted.

#### *Report of the President*

Doctor Alfred L. Potter, president, reported briefly on the preliminary plans for a sesquicentennial Celebration Committee for the Society, indicating some of the projects that such a Committee might undertake.

He briefly discussed the hearings on the Forand Bill to extend Social Security benefits to include hospital and surgical care.

He reported on the relative value study meeting held in Boston in July under the auspices of the American Medical Association.

He also reported on the conference on aging sponsored by the New England Medical Societies, the New York State Medical Society, and the American Medical Association. He noted that Doctor Alex M. Burgess, Sr., would be chairman of the Rhode Island conference to prepare the state's report for the White House Conference on Aging, to be held in 1961.

#### *Report of the Treasurer*

In the absence of Doctor Beardsley, treasurer, Doctor Hardy noted that the budget drawn by the treasurer had been approved by the Council and was included in the delegates' handbook.

*Action:* It was moved that the budget proposed for 1960 be approved. The motion was seconded and adopted.

#### *Recommendations from the Council*

The secretary noted that there were two recommendations submitted by the Council to the House of Delegates:

1. The Council recommends to the House of Delegates that the Society's official representatives on the Board of Directors of the Rhode Island Blue Cross for the fiscal year starting with the annual Blue Cross meeting in 1960 be: Charles J. Ashworth, M.D., and Charles L. Farrell, M.D.

*Action:* It was moved that the recommendation be adopted. The motion was seconded and passed.

2. The Council recommends that the 1960 dues

assessment for active members more than one year in practice be \$50, and for members in their first year of practice, \$25.

*Action:* It was moved that the recommendation be adopted. The motion was seconded and passed.

### *The Rhode Island Plan*

The Rhode Island Plan with insurance companies was discussed by members of the House, after which the following actions were taken:

It was moved that the House of Delegates of the Rhode Island Medical Society discontinue the Rhode Island Plan.

The motion was seconded and passed.

\* \* \*

It was moved that the secretary of the Society be instructed to notify all insurance companies approved under the Rhode Island Plan as soon as feasible, but within thirty (30) days, of the Society's termination of the Plan.

The motion was seconded and adopted.

### *Benevolence Fund*

The president noted that the report of the Benevolence Fund was included in the handbook. He urged that all district societies encourage their members to support this fund.

There was discussion of the report.

*Action:* It was moved that the Rhode Island Medical Society send a request at the time the annual dues is assessed the membership asking for a voluntary contribution by each member to the Benevolence Fund of the Society. The motion was seconded and adopted.

### *Committee on Tenure of Officers*

Doctor Stanley D. Simon, chairman of the special committee on tenure of officers and other officials nominated or elected by the Society, submitted his report, copy of which was included in the handbook to the delegates.

The recommendations of the Committee were discussed by the members of the House. Doctor Potter noted that the intention of the Committee was that the acceptance of the recommendations by the House would not make the actions retroactive.

*Action:* It was moved that the report be accepted and the recommendations adopted. The motion was seconded and passed.

### *Social Security Poll*

The president noted that the final results of the poll of the membership on social security coverage had been included in the handbook for the information of the delegates. He noted that a copy of these results had been submitted to the secretary of each district society.

*continued on next page*



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### *Veterans Affairs*

The secretary noted that the report of the Committee on Veterans Affairs was included in the handbook. The report was discussed by members of the House.

*Action:* It was moved that the House refer the report back to the Veterans Affairs Committee for further study relative to action by other state medical associations regarding federal medical care to veterans, and for further clarification of the recommendations it had submitted to the House. The motion was seconded and passed.

### *Medical Defense and Grievance*

Doctor Francis B. Sargent, chairman of the Committee on Medical Defense and Grievance, gave an oral report on the work of his Committee.

### *National Legislation*

Doctor William A. Reid reviewed the action taken in Rhode Island on national health legislation and he reported in detail on the conference held in St. Louis on October 2 and 3 under the sponsorship of the American Medical Association. He discussed the various situations anticipated in 1960 in view of the fact that this will be an election year.

### *Committee on Medical Economics*

Doctor Stanley D. Simon submitted a lengthy report from the Committee on Medical Economics which answered the request of the House of Delegates for implementation of the recommendations submitted to it at the April, 1959 meeting relative to medical care for the older age group.

*Action:* It was moved that the report of the Committee on Medical Economics as submitted be received and the recommendations therein be approved. The motion was seconded and adopted.

\* \* \*

It was moved that the report of the Committee on Medical Economics be released to the public at the earliest convenience of the chairman and the executive office. The motion was seconded and adopted.

\* \* \*

It was moved that the Committee on Hospital and Professional Relations of the Society and the Chairman and two other members of the Medical Economics Committee selected by him be the Society's delegates to implement the recommendation in the report of the Committee on Medical Economics regarding the establishment of a permanent liaison committee to study the costs of hospitalization. The motion was seconded and adopted.

### *Diabetes Committee*

In the absence of the Chairman of the Diabetes Committee, the executive secretary reported briefly that the Committee plans an intensive educational

campaign the week of November 16 and a Diabetes Fair will be planned for Monday, November 16.

### *Miscellaneous Reports*

The president noted that an outstanding comprehensive report had been prepared by a special committee of the Rhode Island Chapter of the American Academy of Pediatrics, and the Child-School Health Committee of the Society, for submission to the governor's committee for the 1960 White House Conference. He noted that a copy of this report had been sent to each delegate.

A summary on state programs providing medical care for welfare recipients was also submitted to each delegate for information.

### *Adjournment*

The business of the House was completed at 10:24 P.M. and the president declared the meeting adjourned.

Respectfully submitted,

ARTHUR E. HARDY, M.D., *Secretary*

### **REPORT OF THE SECRETARY**

At meetings since the April meeting of the House of Delegates the Council of the Society:

Approved of the appointment by the president of Dr. Alex M. Burgess, Sr. as the Society's official delegate to the New England Postgraduate Assembly planning committee.

Authorized the chairman of the Child-School Health Committee to communicate with the membership of the Society urging an active educational campaign for polio inoculations in the doctor's office, to be done at a fair and reasonable fee, and to be done with no charge for the services for any family that indicated it could not pay.

Expressed its opinion that there is no need at this time for public clinics for polio inoculations except for the indigent.

Approved of the investment of \$1,000 left the Society under the will of Doctor Frederick T. Rogers to establish the F. T. Rogers Fund.

Named Doctors Alfred L. Potter, Samuel Adelson, and Arthur E. Hardy as the Society's voting delegates to the Council of the New England State Medical Societies for the fiscal year 1959-1960.

Appointed Doctor Richard Kraemer as the Society's official delegate to a Washington meeting of the Joint Council to Improve the Health Care of the Aged.

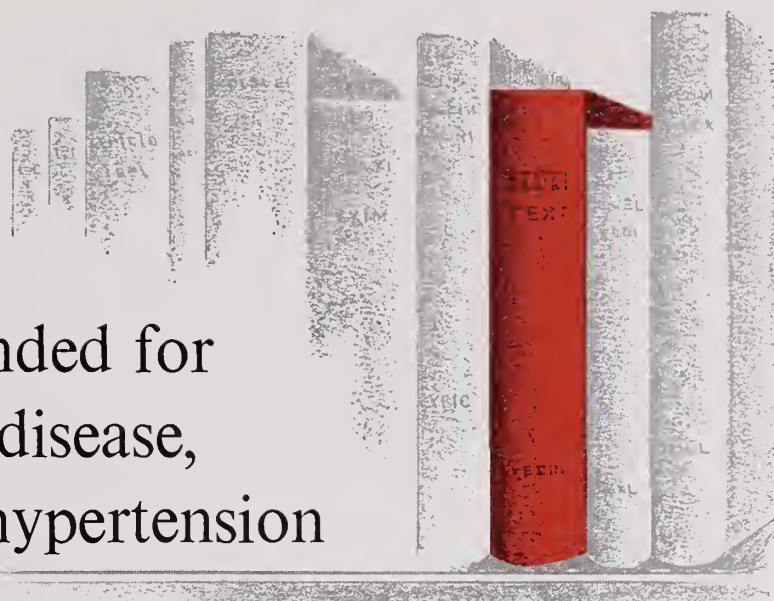
Named Doctor John T. Barrett as the Society's delegate to the A.M.A. sponsored National Conference on Physicians and Schools to be held in Highland Park, Illinois, in October.

Reviewed a poll of the membership on social security coverage for physicians and instructed the Secretary to notify the secretary of each district society of the results of the poll.

*concluded on page 758*



text book  
recommended for  
coronary disease,  
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Theobromine Sodium Acetate (often by its trade name Thesodate) is regularly included in standard text books for classical therapy of coronary heart disease, essential hypertension and for diuresis.\*

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with phenobarbital 30 mg. (½ gr.)

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with phenobarbital 15 mg. (¼ gr.)

Thesodate 0.3 Gm. (5 gr.)

with potassium iodide 0.12 Gm. (2 gr.)

and phenobarbital 15 mg. (¼ gr.)

R.S. Thesodate 0.5 Gm. (7½ gr.)

with Rauwolfia Serpentina 50 mg. (¾ gr.)

\*Paul Dudley White, "Heart Disease" 1951  
(Macmillan) page 480;  
William D. Straud, "Current Therapy," 1955  
(W. B. Saunders) page 102;  
Cecil & Loeb's Textbook of Medicine, 1955  
(W. B. Saunders) page 1,326;  
Wilson & Gisvold, "Textbook of Organic Medicinal and Pharmaceutical Chemistry," 1956  
(Lippincott) page 262;  
Goodman & Gilman, "The Pharmacological Basis of Therapeutics," 1941 (The Macmillan Co.)  
page 281;  
Albrecht, "Modern Management in Clinical Medicine," 1946 (Williams & Wilkins) page 254;  
Friedberg, "Diseases of the Heart," 1956 (Saunders)  
page 285;  
Walter Modell, "Drugs of Choice," 1958-1959  
(C. V. Mosby) pages 100, 475, 615.



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## HOUSE OF DELEGATES

*concluded from page 756*

Referred to the Committee on Social Welfare for study communications relative to the licensure of nursing homes in Rhode Island.

Was informed by the trustees of the Caleb Fiske Fund that a Fiske Prize Essay Competition will not be held for 1959.

Approved of the decision of the president to appoint Doctor Robert Drew of Warren as trustee-at-large on the Board of Trustees of the Medical Library Building for the year 1960.

Authorized a donation of \$50 to aid the work of the National Society for Medical Research, and \$200 to assist the North East Blood Bank Clearing Bureau, maintained by the Blood Banks Association of New York.

Named Doctor William A. Reid and the executive secretary to represent the Society at a National Legislative Conference to be held in St. Louis in October.

Acknowledged a \$200 contribution to the Benevolence Fund from the Woman's Auxiliary of the Society.

Approved of the budget proposed by the treasurer for 1960, and of the assessment of dues to meet the proposed budget.

Referred to the Committee on Medical Economics for study and possible report to the House the subject of a Relative Value Schedule.

Agreed that the Sesquicentennial year of the Society should be celebrated from the time of the Annual Meeting in 1961 until the Annual Meeting in 1962.

ARTHUR E. HARDY, M.D., *Secretary*

## BENEVOLENCE FUND

The Benevolence Fund had a cash balance in the savings department of the Industrial National Bank in Providence on January 1, 1959, of \$3,991.14.

The Providence Medical Association made a special appeal to its membership in January at the time the annual dues were assessed, and the Washington County Medical Society did likewise. As the result of these actions, many physicians made individual contributions to the Fund. In addition the Woman's Auxiliary and the Medical Bureau of the Providence Medical Association made contributions.

The Fund, as of October 1, 1959, had received contributions in 1959 in the amount of \$3,775.00, and with savings account interest of \$76.40, the total receipts to this date amounted to \$7,842.54.

Donations to aid physicians during 1959 have amounted to \$1,500, leaving a cash balance of \$6,342.54 as of October 1.

The trustees have also voted to provide family Blue Cross and Physicians Service coverage to

assist four physicians who have been unable to practice because of serious illness resulting in financial hardship.

The trustees urge every member of the Society to include the Benevolence Fund as a foremost agency to receive a contribution annually. Money given to the Benevolence Fund is tax deductible.

Respectfully submitted,

*Trustees of the Benevolence Fund:*

DAVID FREEDMAN, M.D.

GEORGE W. WATERMAN, M.D.

HENRY J. HANLEY, M.D.

**SPECIAL COMMITTEE ON TENURE OF OFFICERS, COMMITTEE CHAIRMEN, DELEGATES AND OTHER OFFICIALS NOMINATED OR ELECTED BY THE SOCIETY**

This committee, authorized by the House of Delegates at its April meeting, 1959, and subsequently appointed by the president of the Society, reviewed the by-laws of the Society and the procedures and rules and regulations governing the election, nomination, or appointment of members of the Society to represent the Society officially.

The Committee does not believe that the by-laws should at this time be amended. Rather, it recommends to the House of Delegates that the House adopt as a stated policy the following recommendations:

1. That the secretary and the treasurer of the Society, elected annually, serve not more than five successive terms.
2. That the delegate to the House of Delegates of the American Medical Association, elected bi-annually for a two-year term, serve not more than three successive terms.
3. That a member shall not serve for more than three (3) successive terms as chairman of the same Standing or Appointed Committee.
4. That no member shall be nominated for more than two (2) successive three-year terms to the board of directors of the Rhode Island Medical Society Physicians Service.

Respectfully submitted,

*Committee on Tenure of Office*

SAMUEL ADELSON, M.D.

IRVING A. BECK, M.D.

FERDINAND S. FORGIEL, M.D.

HENRI E. GAUTHIER, M.D.

EDMUND T. HACKMAN, M.D.

JAMES A. McGRATH, M.D.

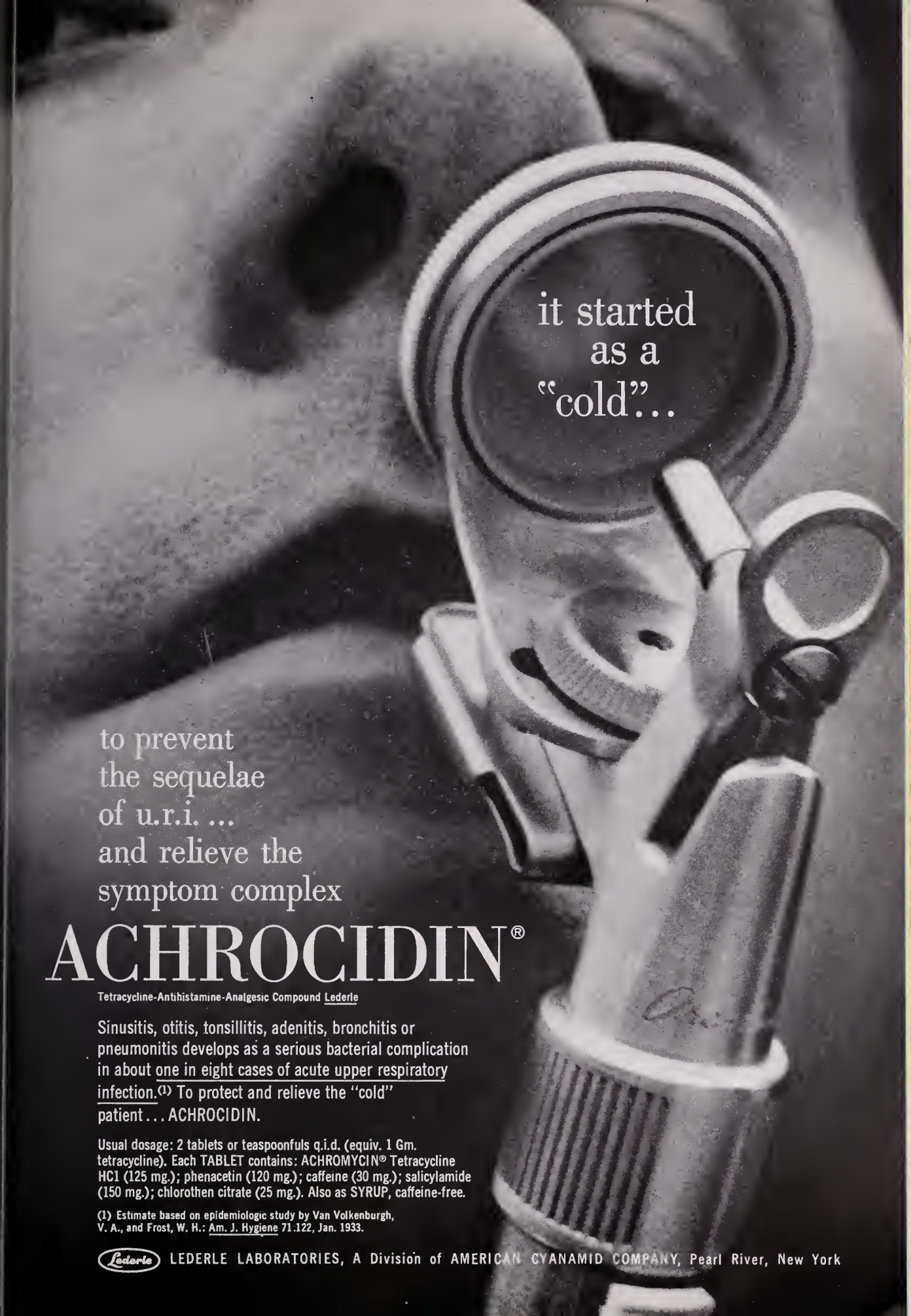
JOHN C. HAM, M.D.

STANLEY D. SIMON, M.D., *Chairman*

ALFRED L. POTTER, M.D.

ARTHUR E. HARDY, M.D.





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(1) Estimate based on epidemiologic study by Van Volkenburgh, V. A., and Frost, W. H.: *Am. J. Hygiene* 71:122, Jan. 1933.



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## THE WASHINGTON SCENE

(A Report Prepared by the Washington Office  
of the American Medical Association)

THE U.S. Chamber of Commerce and two key Congressmen, all opponents of the so-called Forand bill, recently issued separate warnings that an all-out effort will be made to get the controversial legislation through Congress next year.

In its weekly report to members, the Chamber predicted there will be "a powerful attempt" in the next session of Congress to enact the bill (H.R. 4700) which would increase social security taxes to help pay for the cost of the Federal government providing surgical and hospital care for social security beneficiaries.

The Chamber warned that passage of the legislation would mark "a major break-through into the welfare state." It "probably would lead to a compulsory Federal program providing complete medical care for everyone," the Chamber said.

There would be "no stopping" of such a program once it got started, the report said.

The Chamber called upon communities to find orderly solutions to the problems of the aging. Otherwise, solutions "will surely be imposed from Washington," the report added.

Similar warnings were voiced by Reps. Richard M. Simpson (R., Pa.) and Thomas B. Curtis (R., Mo.), key members of the House Ways and Means Committee where the bill was put on the shelf last session.

Rep. Curtis urged that the medical profession and other leading opponents make a strong counter-drive in an all-out effort to block passage of the bill next session. Unless there is such action, he said he would have to "regretfully" predict that legislation along the lines of the pending bill probably will be enacted in 1960.

Rep. Simpson said that H.R. 4700, and similar legislation affecting the medical profession, "make it imperative that every doctor keep informed on legislative issues before Congress." He also urged that physicians "become patriotic political forces" by giving "their informed viewpoint" to lawmakers at all levels of government.

Rep. Simpson said it "is important" that opponents of H.R. 4700 develop "appropriate alternatives" to solve the health care needs of the aged.

He promised to continue to co-operate with the medical profession to guard "against the disastrous consequences of compulsory national health insurance.

"House Democratic Leader John McCormack of Massachusetts expressed hope that Congress next year will stamp final approval on another bill of particular interest to physicians. He praised the Keogh-Simpson bill (H.R. 10) as 'meritorious legislation' and said it 'should be enacted into law next year.'" The measure, which was passed by the House last spring but left hanging in the Senate Finance Committee, would provide income tax deferrals for self-employed persons setting aside money for private retirement plans.

A National Republican Committee on "Program and Progress" proposed a far-reaching health program to be carried out by the Federal government in partnership with states and local governments.

Its goals would include: enlarging the capacity of medical schools so that 3,000 more doctors could be graduated each year, providing more hospital and nursing home beds, and supplementing hospital facilities with clinics, day-care centers and more visiting nurses to care for patients in their own homes.

The progress of medical science would be furthered by continued Federal support for basic medical research. But such Federal support would be given under conditions to encourage maximum non-Federal spending on medical research and to prevent "too great a diversion . . . of doctors required for the equally urgent needs of teaching and medical practice." It was estimated that expenditure of \$1 billion a year — equally divided between the Federal Government and non-Federal sources — would be required by 1965.

Other recommendations included: vigorous Federal support of preventive health programs, and expansions and greater flexibility of voluntary health insurance programs.

"A free people and a free medical profession can achieve these goals with the wise support of government, without bureaucratic restrictions or interference with the physician-patient relationship which has made American health services a model for the free world," the Republican Committee stated.

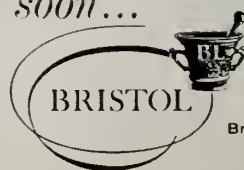
The Committee proposed a five-point "partnership" program: 1) short-term Federal aid for construction of medical school buildings, 2) changes in the present hospital construction program to encourage renovation and repair of outmoded hos-

*concluded on page 779*



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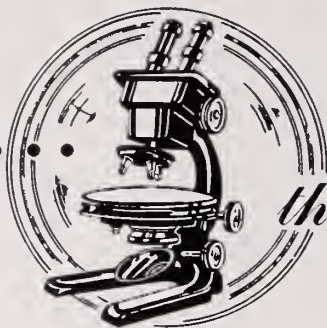


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EFFICACY VIA THE SAFER ORAL ROUTE?

This question will be answered soon...



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*the Microscope*

### *Hospital Admissions Rise as Length of Stay Drops*

In the last twenty years the rate of hospital admissions in this country has greatly increased for almost all diagnostic conditions. Today's hospital patient, however, usually goes home much sooner.

These contrasting trends in the use of general hospitals were analyzed recently by Health Information Foundation.

The Foundation compared data from U.S. Public Health Service studies from 1928 to 1943 with hospital-admission data for July 1957-June 1958 derived from the Public Health Service's current National Health Survey.

During the twenty-year period, the Foundation reported, hospital utilization increased by about 20 per cent, from 715 to 851 patient-days per 1,000 population. The average American now spends almost one day for each year of life in a general hospital.

The trend in utilization results from two factors: a rise of almost 80 per cent in admission rates (from 56 to 99 admissions per 1,000 population) partly offset by a decrease of about one-third (from 12.5 to 8.6 days) in the average length of stay per patient.

The increase in admissions resulted largely from the growth in hospitalization for obstetrical reasons. Twenty years ago, the Foundation said, less than 40 per cent of all babies born in this country were delivered in hospitals. Now, with infant and maternal mortality at all-time lows, the figure is about 95 per cent. Obstetrical cases had little effect on the increase in total days of care, though, since average length of stay per patient dropped from 10.1 to 4.4 days.

The Foundation found that admission rates for two common surgical procedures, tonsillectomies and appendectomies, declined by more than half during the period studied. At the same time, admission rates for most other operative procedures increased; for example, the rates quadrupled for surgical patients with ulcers, hemorrhoids, and

heart diseases. These changes, the Foundation noted, undoubtedly resulted from the use of modern medical techniques, such as new surgical procedures and drugs.

Although admissions rose sharply in all adult age groups, the hospitalization rate for children under 15 actually dropped — mainly because of the decline in tonsillectomies and appendectomies.

### *Tinted Devices Declared Detrimental to Night Driving*

The use of any night driving lens or windshield, whether tinted, reflecting or polarizing, has been condemned by the Committee on Industrial Ophthalmology of the American Medical Association's Council on Industrial Health.

The committee — whose concern is the functions and diseases of the eye as related to industry — delivered its opinion in the October 17 issue of the A.M.A. Journal, after receiving many inquiries.

Its opinion is:

— That a night driving lens or windshield reduces the light transmitted to the eye, and actually makes seeing at night more difficult.

— That the source of night driving glare is the contrast between the headlights of oncoming cars and the darker surroundings. This contrast is not reduced by the use of tinted lenses or windshields. Instead, they really reduce the intensity of illumination from both the headlights and the surroundings. This impairs vision.

— That there is no scientific evidence to support any claim that the use of tinted lenses or windshields improves night vision.

### *Northeast Tops in Health Coverage*

The Northeast region leads the nation in health insurance coverage, the Health Insurance Institute reported in October.

The nine states comprising the Northeast boast a greater percentage of population with health insurance than the nation's other three regions — the Midwest, the West and the South. And one of the region's states, New York, surpasses all other states in this field.

Some 36 million persons in New York, New Jersey, Pennsylvania, Connecticut, Rhode Island, Massachusetts, Maine, Vermont, and New Hampshire have health insurance out of the region's total population of 43 million, for a leading figure of 84.1% covered. Based on a total of 123 million persons with health insurance out of a national population of nearly 174 million at the end of 1958, some 71% of the people in the U.S. are insured against medical care costs.

The percentage for New York State, where 14.7 million persons out of 16.3 million have health insurance, is 90.5%. This is only slightly ahead of the No. 2 state, Connecticut, which has 89.5% coverage based on two million insured out of a possible 2.3 million.

Ohio is the leading state in the Midwest with a figure of 86.3%, trailed by Illinois (83.0%) and Michigan (79.9%). Colorado tops the West with 70.7%, followed by Washington (67.0%) and California (66.7%).

The leading state in the Southern regional grouping is Delaware with 75.8%. Other top states in the area are West Virginia (71.8%), Oklahoma (66.9%), Maryland (64.1%) and Tennessee (62.0%).

The state with the lowest coverage figure is Alaska with 24.6%. Hawaii has 42.2%.

Completing the roll of states with 75% coverage or better are Pennsylvania (86.7%), RHODE ISLAND (83.2%), Vermont (81.0%), Massachusetts (77.8%), Minnesota (77.7%) and Indiana (75.0%).

### *Poison Control Center Established for Rhode Island*

Since October 1 Rhode Island has had its own Poison Control Center, based at Rhode Island Hospitals. Established under the joint auspices of the hospital and the state Department of Health, the center is staffed on a twenty-four-hour basis to give doctors and hospitals speedy and up-to-date information concerning the ingredients in any of some 700 trade name drugs and products used in the home that could be a source of human poisoning. Previously the nearest such center was in Boston.

### *Hospitals Alerted to Prepare for Nuclear Accidents*

The nation's hospitals have been warned to get ready to handle victims of nuclear accidents which can be expected to result from increased peacetime use of the atom.

The warning came from a panel of authorities, including the medical directors of the Oak Ridge and Brookhaven National Laboratories.

In a report issued by Medical Nuclear Consultants, Inc., the experts set minimum facilities,

equipment and personnel training standards for hospital nuclear emergency programs.

At present, no nongovernmental hospital in the country is ready to provide adequate examinations for persons suspected of contamination or to care for more than a very few nuclear casualties at a time, according to the report.

But, the experts added, many hospitals could develop adequate nuclear accident programs without major construction or capital expenditure.

"Many of the facility and equipment needs for the care of radiation victims can be met with the standard resources of the average well-planned and operated institution," according to the report. "A functional prerequisite is a comprehensive emergency plan providing for the availability of these resources in time of need, but allowing for their routine utilization — in diagnosis, therapy and research — at other times."

Recommending that hospitals carry out continuing training programs for physicians and technicians who ultimately might be responsible for handling nuclear casualties, the report says, "The realistic approach to the nuclear emergency problem involves continuous daily training and experience rather than beginning after a radiation accident."

Declaring that "there is sufficient justification" for planning and preparing facilities for care of radiation exposure victims, the report points to nuclear accidents which have occurred at Argonne, Los Alamos, Oak Ridge, Chalk River and in England, Russia and Yugoslavia.

The report says that hospitals should anticipate "emergency situations" in the following areas: the nuclear reactor program, with about 370 reactors under construction or definitely planned in the United States; power reactors in use by or planned by the Armed Forces and maritime service; nuclear weapons being transported or stockpiled; fissionable materials and waste materials being transported from reactor to processing plant, and general use of radioactive materials in industry, medicine and research.

"The probability of radiation injury associated with each of these areas of nuclear use is small on the basis of individual cases," the authorities state. "Nevertheless, the sum total of these probabilities adds up to an increasingly significant hazard threat as nuclear materials are handled in ever larger quantities and more diverse circumstances."

Among nuclear emergency facilities required by hospitals, according to the report, are a receiving ward or suite capable of handling contaminated persons, with complete facilities for their decontamination; whole body radiation counter; examination and surgical rooms; a hematology section; a radioassay laboratory; patient care rooms; adequate bone marrow, blood and drug reserves. Optional addi-

*continued on next page*



tional facilities for research and training include a total body irradiation facility and a medical reactor, both of which would also have everyday diagnostic, therapeutic, research and training applications in the hospital.

Facility and equipment costs, depending on anticipated patient load and the extent of optional research and training facilities, would range from \$50,000 to \$500,000, according to the report. A medical reactor would cost an additional \$500,000.

#### *Graduate Fellowships in Industrial Medicine*

The University of Cincinnati's Institute of Industrial Health is offering graduate fellowships in industrial medicine. The Institute, which is in the College of Medicine, provides professional training for graduates of approved medical schools who have completed at least one year of internship.

The three-year program leading to the degree of Doctor of Industrial Medicine satisfies the requirements for certification in occupational medicine by the American Board of Preventive Medicine. Two years are devoted to intensive academic and clinical study in the field of industrial medicine. A third year is spent in residency in an industrial medical department or in some comparable organization.

Stipends for the first two years vary from \$3,000 to \$4,000 depending upon marital status. In the final or residency year the fellow is compensated by the organization in which he is completing his training.

#### *Weight Tables Change as the Result of New Study*

Women weigh distinctly less than a generation ago, while men tend to be heavier than their fathers.

This is just one of many significant findings of the largest statistical investigation undertaken in the health field, published last month by the Society of Actuaries under the title *1959 Build and Blood Pressure Study*.

The new average weights developed will change the tables now used on weighing machines and in doctors' offices, which were based on an actuarial study of thirty years ago.

The weights of women in their twenties average at least five pounds less than three or four decades ago. In fact, women of all ages now tip the scales several pounds lower. This is partly due to lighter clothing but reflects mainly the established vogue of slenderness that has outmoded Lillian Russell as the ideal figure.

In contrast, the average weights of short and medium height men in their twenties and thirties are now about five pounds higher. The increase in men's weights at other ages and also for tall men has been generally smaller. While the proportion of overweights has changed little over the years in both sexes, the proportion of men who are underweight has diminished, while the proportion of underweight women has increased appreciably.

Average weights for both men and women increase with advance in age through the fifties. However, the pattern of the increases in weights is different in the two sexes. Men start putting on weight in the twenties and level off in the forties, but women stay slim into the thirties and do not usually start putting on weight until after the mid-thirties.

#### *Surgeons to Meet in Boston in February*

The American College of Surgeons has announced a four-day Sectional Meeting for surgeons and nurses to be held in Boston from February 29 through March 3. Dr. Claude E. Welch is local

*concluded on page 770*



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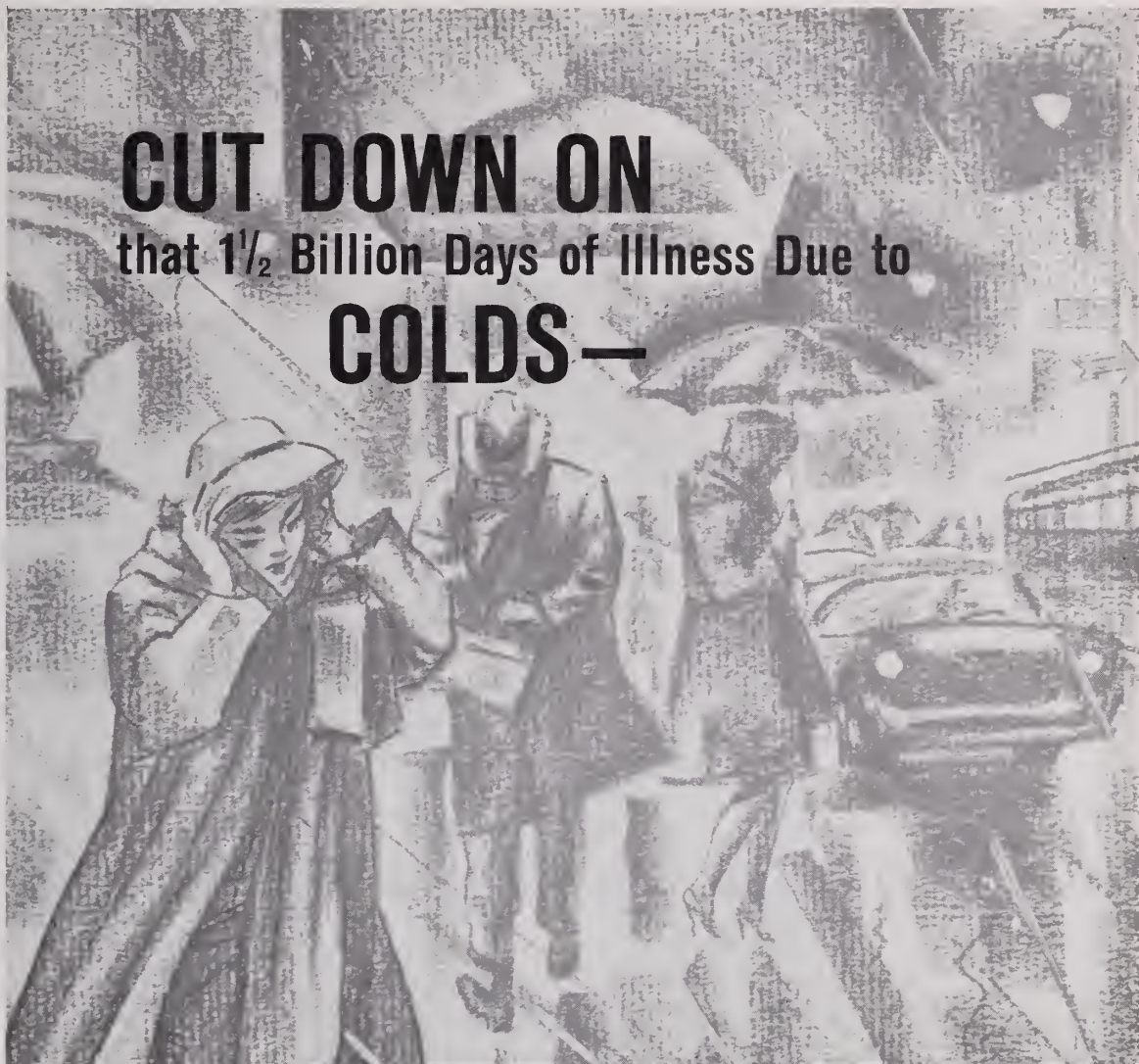
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### PROTECTION from Nasal Stuffiness

— Neo-Synephrine HCl, 5 mg. — first choice in decongestants.

### PROTECTION from Aches, Fever

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DOSAGE: Adults—2 tablets three times daily.

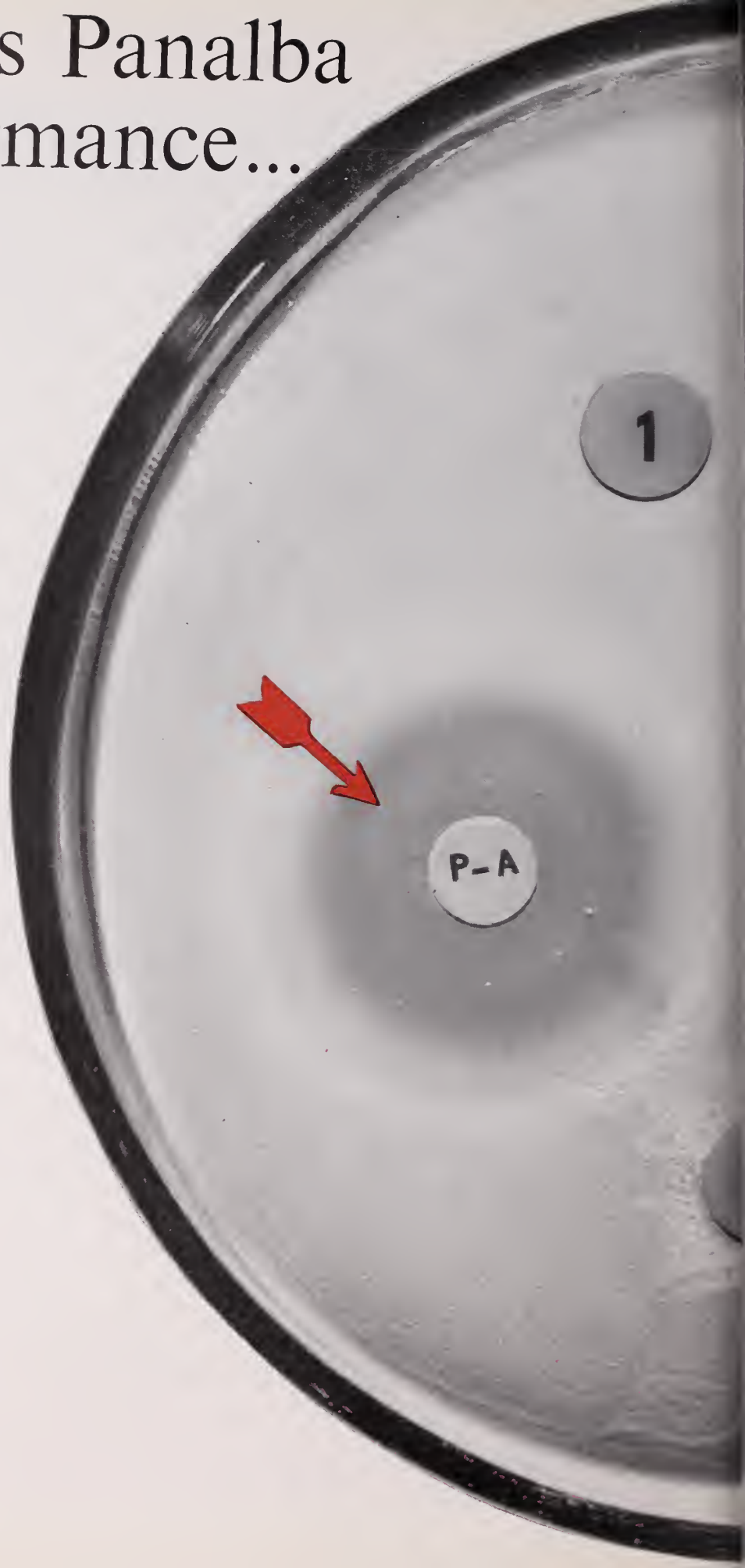
Children from 6 to 12 years—  
1 tablet three times daily.

Bottles of 20 and 100 tablets.

Neo-Synephrine (brand of phenylephrine) and Thenfadiol (brand of phenylamine), trademarks reg. U. S. Pat. Off.



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# in pneumonia

... into a mixed culture of the three organisms commonly involved in pneumonia . . . *K. pneumoniae*, *Diplococcus pneumoniae*, and *Staphylococcus aureus* (in this case a resistant strain) . . . we introduce the five most frequently used antibiotics.

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*first* resort

**Upjohn**

The Upjohn Company  
Kalamazoo, Michigan



\*TRADEMARK, REG. U.S. PAT.

## THROUGH THE MICROSCOPE

*concluded from page 766*

chairman of the program for the surgeons which will be presented at meetings at the Statler-Hilton hotel.

*Barbiturate Addiction More Damaging*

Addiction to barbiturates is more damaging to a person than addiction to heroin and other opiates, according to the current issue of *Patterns of Disease*, a Parke, Davis & Company Publication for the medical profession.

"The barbiturate addict," says *Patterns*, "is more disabled than the opiate addict in terms of thinking, judgment, reaction time, and general intellectual functioning." Moreover, barbiturate withdrawal "unless properly managed, may result in death."

How many barbiturates addicts are there in the United States? The numbers are not known, since these drugs do not come under the control of the Federal Bureau of Narcotics. But the annual consumption of barbiturates in this country is an estimated 300 tons. And more people die from taking barbiturates, either accidentally or intentionally, than any other poison.

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The real issue is not the specific provisions of the Forand Bill, but rather the basic principle involved. Any Forand-type legislation would raise the same danger. It would add service benefits to a Social Security program which so far has been limited to cash payments based on the "floor-of-protection" concept.

This new principle, as you know, would alter the nature of the Social Security program. It would pave the way for evolution of a system of tax-paid health care for the entire population. Every two years—in the even years of federal elections—the push for amendment and expansion would be under way. The continuing trend would first undermine, and eventually destroy, our system of voluntary health insurance and the private practice of medicine.

... LOUIS M. ORR, M.D., *President of the American Medical Association*, speaking before the 68th annual meeting of the Association of Life Insurance Medical Directors of America, at New York, October 22.

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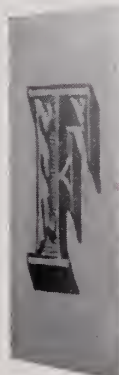


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Thiamine HCl (B <sub>1</sub> )	10 mg.
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Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
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\*Hirsch, H. A., and Finland,  
*New England J. Med.*, 260:  
(May 28) 1959

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(Warning: May be habit-forming)		
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Pyrilamine Maleate	12.5 mg.	
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Literature  
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Your doctor, specialist or surgeon has spent nearly half his expected lifetime preparing for the medical profession. He has directed his efforts toward medicine alone — through a maze of preparation.

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*Better Health Care for More People Through*

# *Physicians Service*



---

## NEW HATTIE IDE CHAFFEE HOME IN EAST PROVIDENCE

---

ON March 12, 1947, Mr. Walter Chaffee of East Providence gave to the Rhode Island Cancer Society, in memory of his mother, Hattie Ide Chaffee, a dwelling house to be used as a home for cancer patients. The state cancer society completely renovated the house to make it suitable for a nursing home, and many local community organizations and groups donated hospital beds and other equipment. A total bed capacity of fourteen was realized, and through the years there has been a continuous waiting list of patients seeking admission.

A reorganization was effected that placed the home under the administration of a nonprofit corporation distinct from the state cancer society. In view of the demand for bed space the new governing board purchased a sizable tract of land on Wampanoag Trail in April, 1957, and initiated a public drive for funds for the erection of a new hospital.

Below is pictured the new Hattie Ide Chaffee Home which will accommodate forty-five patients in a specially designed modern facility. The new

home, to be opened about the first of January, also includes a superintendent's suite, rooms for the cook and for the building custodian, a general office and waiting room, a doctor's conference room, and a large lounge, a hobby room, and a chapel for use by the patients. In a basement room space is provided for laboratory and X-ray facilities.

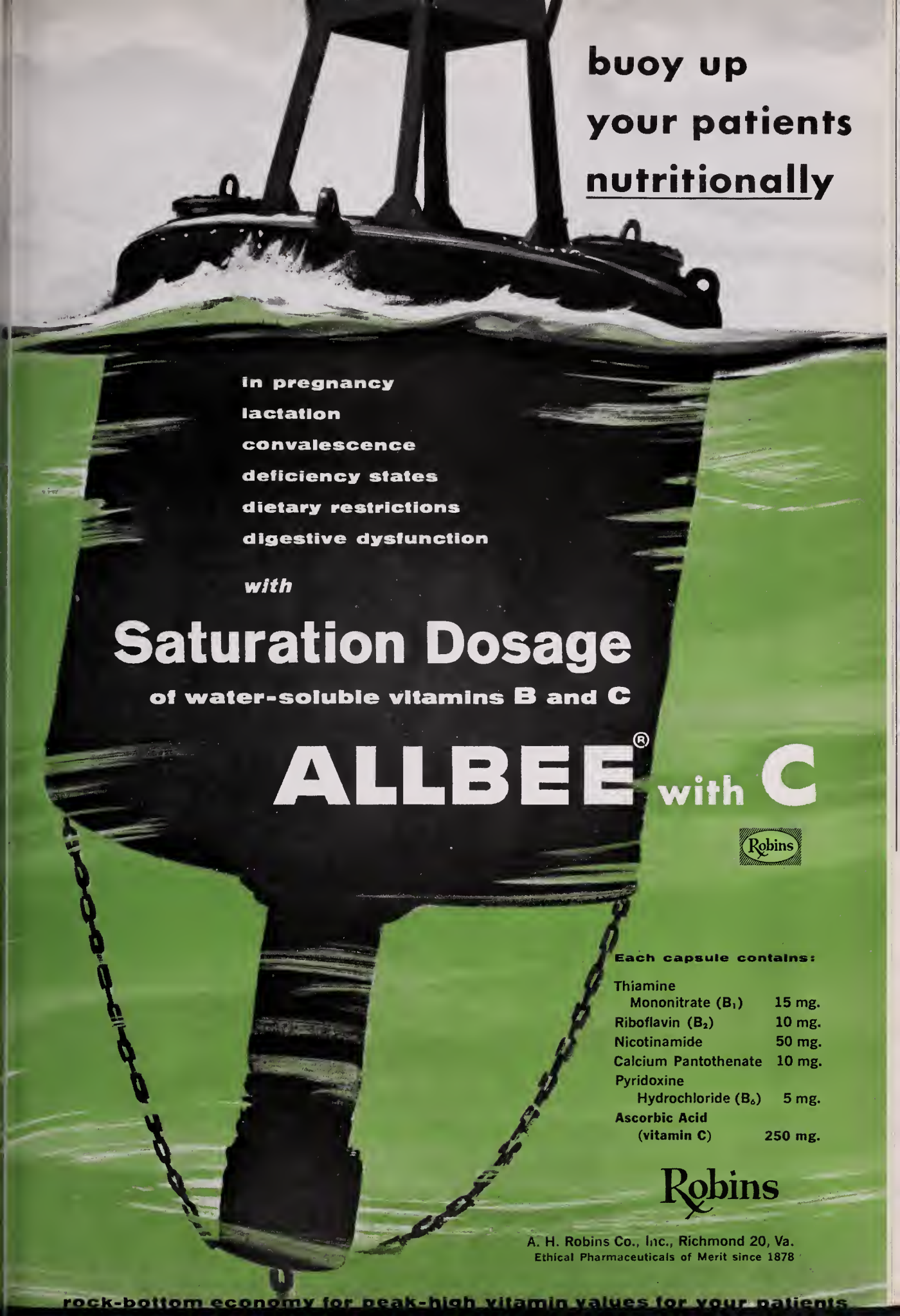
The medical care at the present home has been carried on by four physicians who are engaged in private practice in East Providence. This staff will be increased for the new home, and in addition any member of the Rhode Island Medical Society may send patients to the Home, and care for them himself in co-operation with the official staff.

Notice of the days for public inspection of the new Hattie Ide Chaffee Home will be widely publicized in the very near future, and the trustees of the Home particularly extend to the members of the Rhode Island Medical Society their invitation to visit Rhode Island's newest facility for the care of cancer patients.



New Hattie Ide Chaffee Home to be opened in East Providence about the first of January for care of cancer patients.

---



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Hydrochloride (B <sub>6</sub> )	5 mg.
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## BOOK REVIEWS

*PREVENTIVE MEDICINE.* Principles of Prevention in the Occurrence and Progression of Disease. Edited by Herman E. Hilleboe, M.D., and Granville W. Larimore, M.D. W. B. Saunders Company, Phil., 1959. \$12.00

This is an excellent book on public health and preventive medicine for the public health physician as well as the private practitioner for whom it was primarily written. It was edited by the Commissioner and the Deputy Commissioner of Health of the State of New York. The various chapters were contributed by the staff of the New York State Health Department. It is a very practical book, written by a staff who not only are teachers but also practicing public health officials. It is compact and the authors are to be commended for their brevity. As a result, the reader gets only the essentials of the various subjects.

Perhaps the philosophy of the editors is best stated in the introduction as follows "There is much in this book to interest the private practitioner. He will discover that he and the public health physician have a common mission: to eliminate disease and suffering. Both are supported in this pursuit by a common pool of medical knowledge to which each contributes, and from which each draws in equal measure. Private practitioners of today are as much in the business of preventing disease and disability as their colleagues in public health."

As the subtitle *Principles of Prevention in the Occurrence and Progression of Disease* suggests, it is emphasized that preventive medicine does not stop with the prevention of disease alone, but concerns itself with stopping the progression of disease once it has already occurred.

The book is divided into three main parts: 1. *Prevention of Occurrence*; 2. *Prevention of Progression*; and 3. *Supporting Services for Preventive Medicine*. Under these three main headings almost every phase of public health is explored.

Under part one, *The Prevention of Occurrence*, is included the control of environmental factors as they relate to disease prevention. Everything from a safe, potable water supply to medical defense against atomic attack or natural disaster is covered. Another section of part one includes *Prophylactic Measures Against Disease*, discussing diseases according to etiology — bacterial, viral, rickettsial, etc. The rest of this section is devoted to such sub-

jects as nutrition, obesity, preventive health services in childhood, and dental health.

Part two, *Prevention of Progression of Disease*, discusses screening methods for various diseases, rehabilitation, alcoholism and drug addiction.

Part three, *Supporting Services for Preventive Medicine*, includes a variety of chapters on those aids available to the private physician: such as education, public health nursing, social work, the role of the hospital and voluntary and official health agencies.

This is an excellent reference for the busy practicing physician. A great deal of material has been condensed into a compact book which the physician can pick up and lay down at will and find much each time to satisfy him.

RAYMOND F. MCATEER, M.D.

*NOW OR NEVER.* The Promise of the Middle Years by Smiley Blanton, M.D., with Arthur Gordon. Prentice-Hall, Inc., Englewood Cliffs, N. J., 1959. \$4.95

This is a difficult book to review, especially for a medical library. It is written for the laity and offers common sense advice on problems common to all.

Doctor Blanton writes informally, using many brief case histories as illustrations of his points. He covers many subjects such as marriage, work, money, alcohol, sex, religion, aging parents and your own old age.

He has done psychiatric counselling for more than forty years and has been associated with Norman Vincent Peale in the American Foundation of Religion and Psychiatry.

This is a book which should be available in all public libraries and one which we, as doctors, could read with profit and recommend to our patients.

AMY E. RUSSELL, M.D.

## THE WASHINGTON SCENE

*concluded from page 761*

pitals, 3) Federal guarantees for mortgages to finance construction of private nursing homes on a basis assuring high standards of quality in construction and operation, 4) encouragement of construction of diagnostic and outpatient facilities in rural area and the building of mental health clinics, and 5) Federal aid to cities "in more effective planning and co-ordination of health services."

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ACCOMPANIED BY AN  
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*This question will be answered soon...*





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# RHODE ISLAND



DECEMBER, 1959

## Medical Journal

Volume XLII, No. 12

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**bibliography:** (1) Green, J. R., & Steelman, H. F.: *Epileptic Seizures*, Baltimore, Williams & Wilkins Company, 1956, p. 136. (2) Brody, P. F.: *Pediatrics* 23:151, 1959. (3) Davidson, D. T., Jr., in Conn, H. F.: *Current Therapy* 1959, Philadelphia, W. B. Saunders Company, 1959, p. 512. (4) Smith, B., & Forster, F. M.: *Neurology* 4:137, 1954. (5) Zimmerman, F. T.: *New York J. Med.* 55:2338, 1955. (6) Lemere, F.: *Northwest Med.* 53:482, 1954. (7) Perlstein, M. A.: *Pediat. Clin. North America*: 4:1079 (Nov.) 1957. (8) Livingston, S., & Pouli, L.: *Pediatrics* 19:614, 1957. (9) Carter, C. H., & Moley, M. C.: *Neurology* 7:483, 1957. (10) Keith, H. M., & Rushton, J. G.: *Proc. Staff Meet. Mayo Clin.* 33:105, 1958.



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December, 1959

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This is Panalba  
performance...







# in bronchitis

... into a mixed culture of the four organisms commonly involved in bronchitis . . . *Str. hemolyticus*, *D. pneumoniae*, *H. influenzae* and *Staph. aureus* (in this case a resistant strain) . . . we introduce the five most frequently used antibiotics.

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3 or 4 times a day.  
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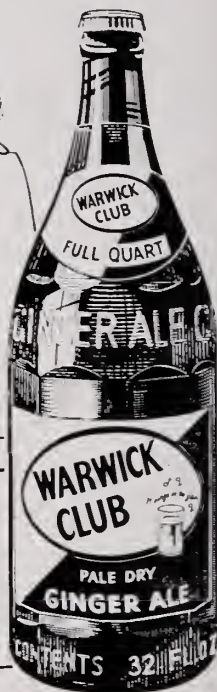


\*TRANSLATION:

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Initiation of therapy in *minutes after diagnosis* with new, ready-to-inject Terramycin Intramuscular Solution provides maximum, sustained absorption of potent broad-spectrum activity.

*...and for continued, compatible,  
coordinated therapy*

## COSA-TERRAMYCIN<sup>®</sup> CAPSULES

oxytetracycline with glucosamine

Continuation with oral Cosa-Terramycin every six hours will provide highly effective antibacterial serum and tissue levels for prompt infection control.

The unsurpassed record of clinical effectiveness and safety established for Terramycin is your guide to successful antibiotic therapy.

*Supply:*

*Terramycin Intramuscular Solution\**

100 mg./2 cc. ampules

250 mg./2 cc. ampules

*Cosa-Terramycin Capsules*

125 mg. and 250 mg.

*Cosa-Terramycin is also available as:*

*Cosa-Terramycin Oral Suspension* — peach flavored,  
125 mg./5 cc., 2 oz. bottle

*Cosa-Terramycin Pediatric Drops* — peach flavored,  
5 mg./drop (100 mg./cc.), 10 cc. bottle  
with plastic calibrated dropper

Complete information on Terramycin Intramuscular Solution and Cosa-Terramycin oral forms is available through your Pfizer Representative or the Medical Department, Pfizer Laboratories.

\*Contains 2% Xylocaine<sup>®</sup> (lidocaine), trademark of Astra Pharmaceutical Products, Inc.



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LEDERLE INTRODUCES...

# a masterpiece



## greater antibiotic activity

Milligram for Milligram, DECLOMYCIN exhibits 2 to 4 times the activity of tetracycline against susceptible organisms. (*Activity level* is the basis of comparison—not quantitative blood levels—since action upon pathogens is the ultimate value.\*) Provides significantly higher serum activity level...

## with far less antibiotic intake

DECLOMYCIN demonstrates the highest ratio of prolonged activity level to daily milligram intake of any known broad-spectrum antibiotic. Reduction of antibiotic intake reduces likelihood of adverse effect on intestinal mucosa or interaction with contents.

## unrelenting peak antimicrobial attack

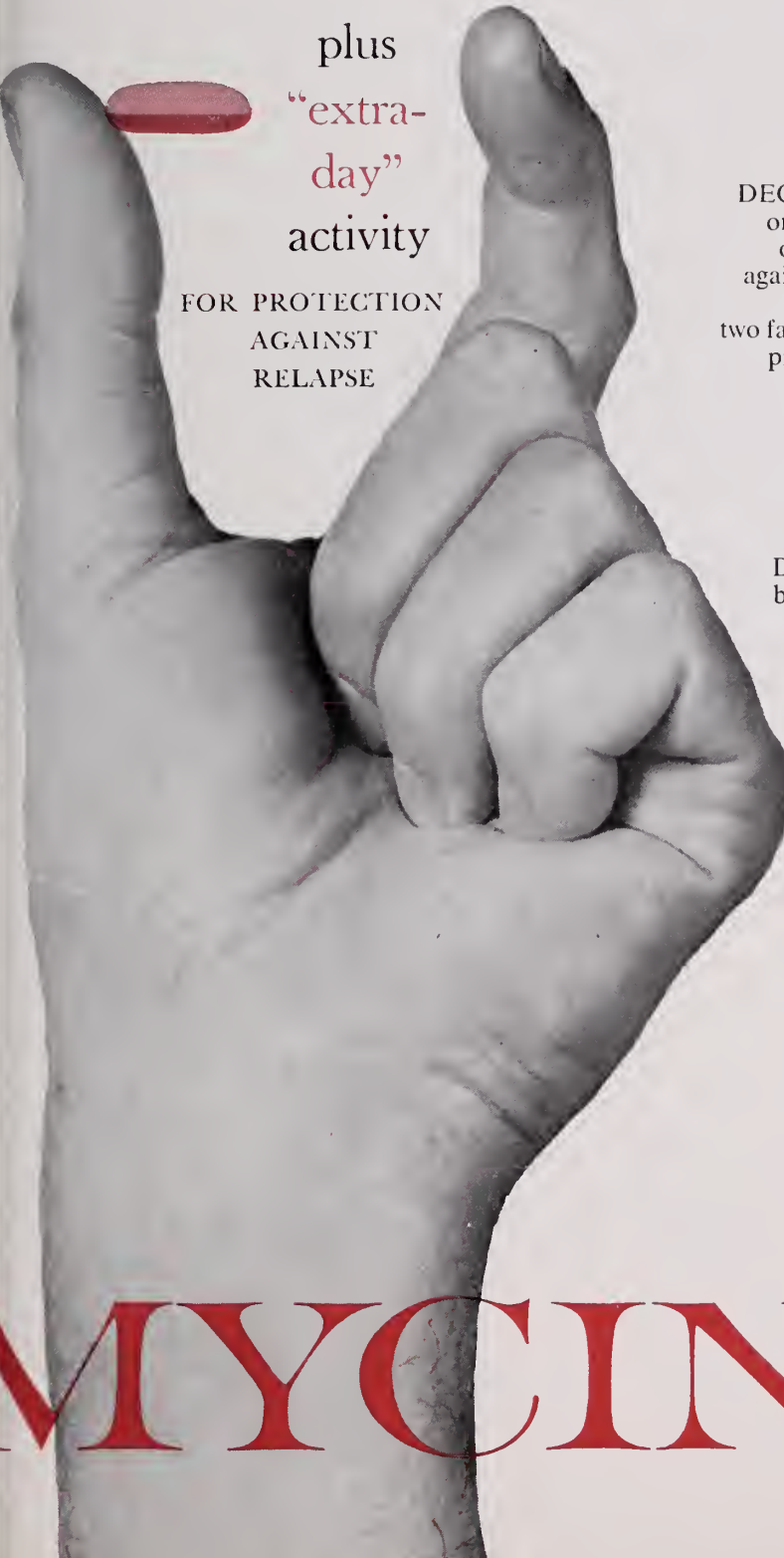
The DECLOMYCIN high activity level is uniquely constant throughout therapy. Eliminates peak-and-valley fluctuation, favoring continuous suppression. Achieved through remarkably greater stability in body fluids, resistance to degradation and a low rate of renal clearance.

\*Hirsch, H. A., and Finland, M.  
*New England J. Med.* 260:115  
(May 28) 1959

# DECLOMYCIN

Demethylchlortetracycline Lederle

# f antibiotic design



plus  
"extra-  
day"  
activity

FOR PROTECTION  
AGAINST  
RELAPSE

DECLOMYCIN maintains activity for one to two days after discontinuance of dosage. Features unusual security against resurgence of primary infection or secondary bacterial invasion—two factors often resembling a "resistance problem"—enhancing the traditional advantages of tetracycline . . . for greater physician-patient benefit

in the distinctive dry-filled,  
duotone capsule

immediately available as:  
DECLOMYCIN Capsules, 150 mg.,  
bottles of 16 and 100. Adult dosage:  
1 capsule four times daily.

# MYCIN<sup>®</sup>



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Pearl River, New York



# Industrial's *Convertible* living trust



## A SPECIAL INVESTMENT SERVICE FOR BUSY MEN

One of the most important benefits of Industrial's *Convertible* Living Trust is its unique flexibility. Thanks to this flexibility, the type of investment service you receive varies in accordance with your requirements.

Under normal circumstances, the *Convertible* Living Trust functions primarily as your investment "bookkeeper," handling the time-consuming chore of detailed record keeping and other paperwork for you. You continue to exercise full control of your own investments.

However, if at any time you become temporarily or permanently unable to

actively manage your investments, the automatic "convertibility" of this Trust permits Industrial National's skilled trust officers to assume management of your estate immediately — for as long a period as your circumstances require.

### **Convertible Living Trust advantages:**

- You and your beneficiaries receive financial services conforming to your actual needs and circumstances at any given time
- Helps avert financial losses in any "change-over" period
- Assures maximum pro-

tection of your investments if your beneficiaries lack investment knowledge or experience

- Takes care of burdensome paperwork for you, now and in the future

Get full information today about our *Convertible* Living Trust. There's no obligation. Write to our Trust Department, Box 1466, Providence, or call Jackson 1-9700, extension 534.

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**NATIONAL BANK**

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basic in exchange

basic in  
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# CORICIDIN<sup>®</sup> Tablets



formula

chlorprophenpyridamine maleate...2 mg.  
aspirin.....0.23 Gm.  
phenacetin.....0.16 Gm.  
caffeine.....30 mg.

L-089

SCHERING CORPORATION • BLOOMFIELD, NEW JERSEY

## new hope for fetal salvage

# DELA

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifstein<sup>1</sup> in a compilation of data supplied by 45 investigators. Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,<sup>2</sup> in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy

64% of 42 pregnancies were salvaged by progesterone

83% of 73 pregnancies were salvaged by Delalutin

Eichner,<sup>3</sup> found that in Delalutin-treated women, fetal salvage of infants below term

weight (1000 to 2000 gm.) was significantly improved. 108 (76%) of 142 babies of this birth weight survived without mothers receiving progestational therapy, while 16 (100%) of 16 babies of this birth weight survived with mothers receiving Delalutin therapy. A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.<sup>4</sup> Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active", well-tolerated and long-acting.

According to Tyler and Olson,<sup>5</sup> "These qualities of prolonged action and relative freedom from local reactions make [Delalutin] a generally more desirable therapeutic agent for intramuscular use than progesterone...."

### DELALUTIN BABIES WHOSE MOTHERS WERE HABITUAL ABORTERS



Mary Ann Cribben  
Garden City, N. Y.



Amy Sue Greenman  
Lincolnwood, Ill.



William Peller  
Skokie, Ill.



Randy Sinis  
Denver, Colo.



Richard Miller  
Denver, Colo.



Scott Knudsen  
Norwich, Vt.

References: 1. Reifstein, E. C., Jr.: *Annals N. Y. Acad. Sc.* 71:762 (July 30) 1958. 2. Boschann, H. W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. & Gynec.* 76:279, 1958. 5. Tyler, E. T., and Olson, H. J.: *J. A.M.A.* 169:1813, 1959.



# DELALUTIN<sup>®</sup>

*improved  
progestational  
therapy*

SQUIBB HYDROPROGESTERONE CAPROATE

DELALUTIN offers these advantages over other progestational agents:

- long-acting sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requiring injection of less vehicle
- unusually well-tolerated, even in large doses
- fewer injections required
- low viscosity makes administration easier

DELALUTIN is also potent and safe therapy for: threatened abortion; postpartum after-pains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated with genital malignancy; infertility with inadequate corpus luteum function; production of secretory endometrium and desquamation during estrogen therapy; premenstrual tension; dysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

## Administration and dosage:

Because of its low viscosity, Delalutin may be administered with a small gauge needle (deep intragluteal injection). Complete information on administration and dosage is supplied in the package insert.

## Supply:

Delalutin is available in vials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

*Each of these healthy, normal babies was born by a mother with a documented previous history of habitual abortion, who was treated during her most recent pregnancy with DELALUTIN.*



Rutkowski  
Roselle, Ill.



Rosanne Guberman  
Elmont, L.I., N. Y.



Kenneth Michael Simonson  
Denver, Colo.



Daniel A. Fabrizio, Jr.  
No. Massapequa, L.I., N. Y.



Verderosa  
Ford, N. Y.



J. Gettemy  
Hartford, Conn.



Karen Mary Nederman  
East Williston, N. Y.

**SQUIBB**



*Squibb Quality—the Priceless Ingredient*

\*DELALUTIN<sup>®</sup> IS A SQUIBB TRADEMARK.



## *Objective: Everyone*

The true community goal of Physicians Service can be best expressed in this way: there is virtually no person in Rhode Island who cannot have health care protection under Physicians Service.

That statement sets Physicians Service apart from other health care plans which may drop members at age 60 or 65, or which do not cover families as such, regardless of the number of children.

By extending protection to 510,000 people — 65% of the State's eligible population, Physicians Service aims to protect everyone — including those who otherwise might not get necessary care.

In aiming to reach those groups which "Can't afford to be sick" or those who might postpone necessary operations, Physicians Service hopes to make its program as all-inclusive as possible. Thus it again provided more protection to subscribers by adding on July 1st, substantial new benefits in mental, tuberculous and chronic cases.

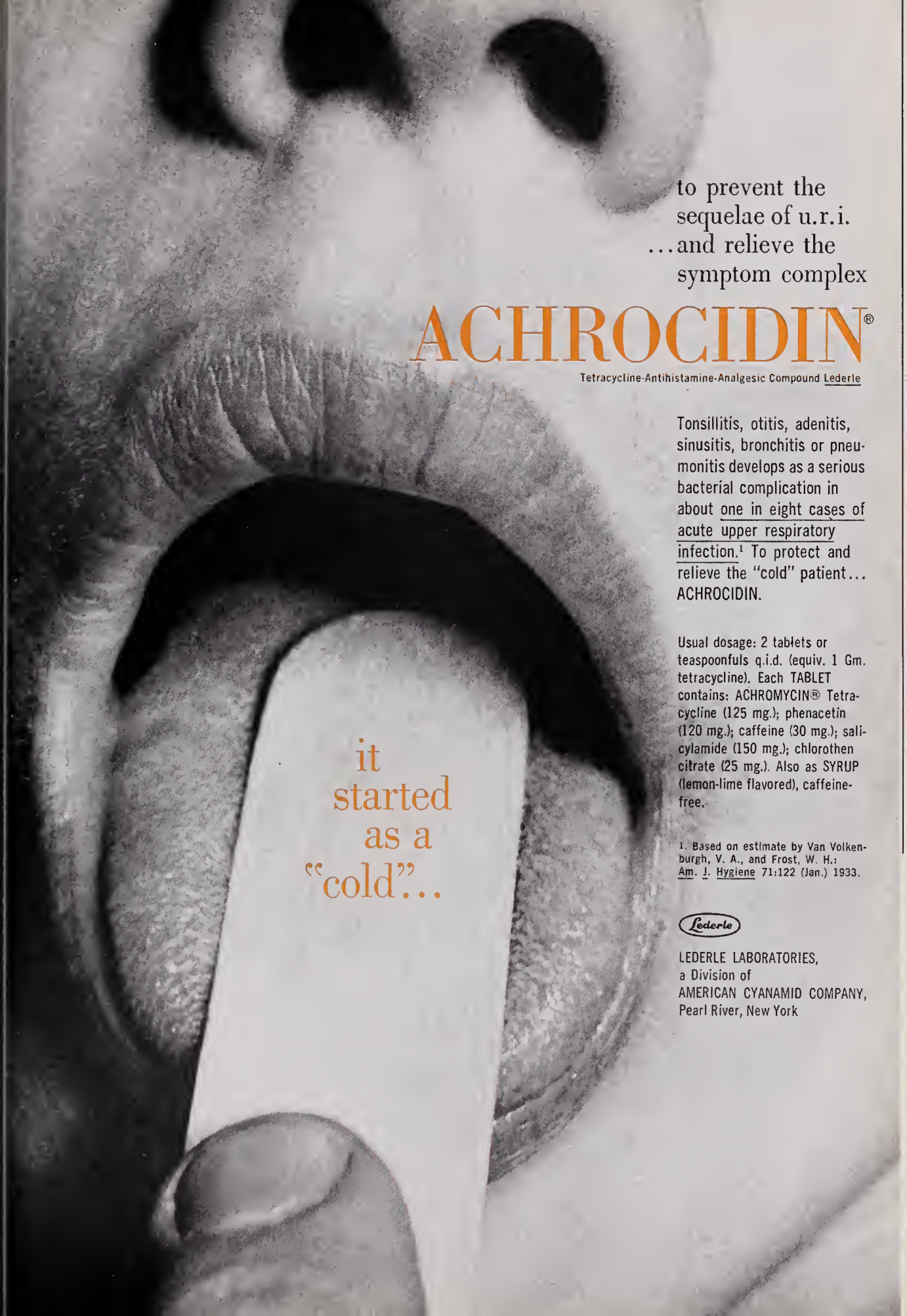
Physicians Service continues to broaden its protection whenever possible — to bring low cost surgical-medical-obstetrical benefits to every subscriber in Rhode Island.

*Better Health Care for More People Through*

# *Physicians Service*







to prevent the  
sequelae of u.r.i.  
...and relieve the  
symptom complex

# ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Tonsillitis, otitis, adenitis, sinusitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.<sup>1</sup> To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933.

it  
started  
as a  
"cold"...



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# The extra-firm mattress selected by over 9,000 doctors for their own use

Assures both preventive and corrective support—used in more American homes than any other special design

Sealy Posturepedic is the first mattress designed in cooperation with leading orthopedic surgeons to promote normal, healthful sleep among *all* persons.

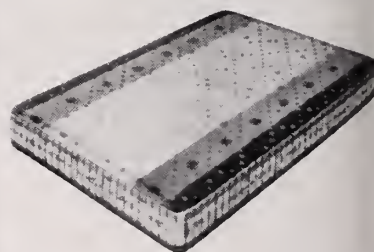
As a "corrective device" it serves those chronically afflicted with lower back syndromes. As a preventive measure Sealy Posturepedic brings deep spring buoyancy without bedboard hardness to everyone—plus the concomitant blessings of unexcelled comfort and extra-firm support.

These are basic to good health. The therapeutic value of restful sleep is especially recognized during these tense and anxious days. Sealy Posturepedic eminently meets this need by supplying level spine support for proper relaxation of the limbs and human muscularatory system.

Over 9,000 doctors of medicine have tried and bought the Sealy Posturepedic mattress and matching foundation for their own use. We believe your investigation will firmly convince you of its distinctive benefits, and, we would hope, merit your valued recommendation.

**Sealy** **POSTUREPEDIC®**  
BRAND

**NO MORNING  
BACKACHE**  
from a too-soft mattress



**PROFESSIONAL DISCOUNT OF \$39.00**

So that you may judge the quality of the Sealy Posturepedic for yourself, we offer a special Professional Discount on this mattress and foundation when purchased for your personal use. *Limit—one full or two twin size sets.*

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Enclosed is my check and letterhead. Please ship the Sealy Posturepedic Set(s) indicated below:

1 Full Size ☐

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Posturepedic Mattress  
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RETAIL  
each \$79.50  
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(This is a saving of \$39.00 per set over the regular \$159.00 retail price for mattress and matching foundation)

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## THE WASHINGTON SCENE

(A Report Prepared by the Washington Office  
of the American Medical Association)

---

A SPECIAL COMMITTEE of consultants to the Federal government has recommended what was termed an urgent, essential program designed to maintain the present ratio of physicians in a sharply expanding population.

Doctor Leroy E. Burney, Surgeon General of the Public Health Service, gave his personal approval to the recommendations made by his 22-member Consultant Group on Medical Education after about a year's study. But he said he couldn't indicate yet "the extent to which they can be incorporated" in next year's proposals of the Department of Health, Education and Welfare.

The Consultant Group recommended expansion of existing medical schools and construction of 20 to 24 new ones with Federal help, federal scholarships for medical students, and greater efforts in the field by states, local communities, foundations, individuals, industry and voluntary agencies.

The Group said the present ratio of 133 doctors of medicine and 8 doctors of osteopathy per 100,000 population is "a minimum essential to protection of the health of the people of the United States."

To maintain this ratio the Group said, "the number of physicians graduated annually by schools of medicine and osteopathy must be increased from the present 7,400 a year to some 11,000 by 1975—an increase of 3,600 graduated.

"To meet the country's need for physicians for medical care, teaching, research and other essential purposes will require an immediate and strenuous program of action by the nation as a whole," the Group's 95-page report stated.

"This program must safeguard and improve the quality of medical education as well as bring about the needed substantial increase in the number of physicians."

The No. 1 recommendation of the Group was for the Federal government to appropriate over the next 10 years funds—estimated at about \$500 million "on a matching basis to meet construction needs for medical education," including necessary teaching hospitals.

"The Consultant Group is convinced that the nation's physician supply will continue to lag behind the needs created by increasing population unless the Federal government makes an emergency financing contribution on a matching basis toward the construction of medical school facilities," the report said.

The Group also said research grants to medical schools "should cover full indirect costs so that medical schools are properly reimbursed for the contribution of medical education to medical research."

These two recommendations were in line with American Medical Association positions on the matters.

The Group also urged "more generous public and private support for the basic operations of medical schools." Such support, the report added, "must come from many sources, including state and local appropriations, endowments, gifts and grants, universities, and reimbursement for patient care."

Most of the consultants were physicians or educators. They included Doctor Julian Price of Florence, S. C., a member of the A.M.A. Board of Trustees, and Doctor Edward L. Turner, director of the A.M.A. Division of Scientific Activities.

Highlights of the Group's report included:

—To maintain the present physician-population ratio, the expected 1975 population of 235 million will require a total of 330,000 doctors of medicine and osteopathy.

—There also must be 12,000 entering students in 1971, as against about 7,600 a year now.

—"In a very real sense, the needs for physicians cannot be met by numbers alone. They will be met only as an expanded program maintains and enhances the quality of medical education."

—The entry of more physicians into research, industrial medicine and similar activities "has made possible much of the progress of modern medicine." But it also has resulted in "relatively fewer physicians devoting full time to patient care."

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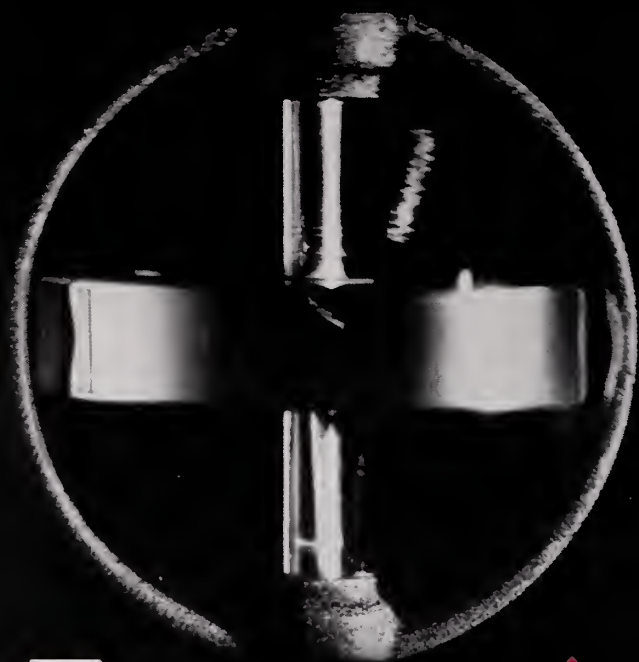
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minimal disturbance  
of the patient's chemical and psychic balance...



*still unsurpassed  
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corticosteroid  
benefits*

**Aris**

*Substantiated by published reports of leading clinicians:*

• **effective control**  
of allergic  
and  
inflammatory symptoms<sup>1-20</sup>

• **minimal disturbance**  
of the patient's  
chemical and psychic  
balance<sup>1, 4, 5, 8-19</sup>



# ARISTOCORT<sup>®</sup>

Triamcinolone LEDERLE

*Anti-inflammatory and antiallergic levels ARISTOCORT means:*

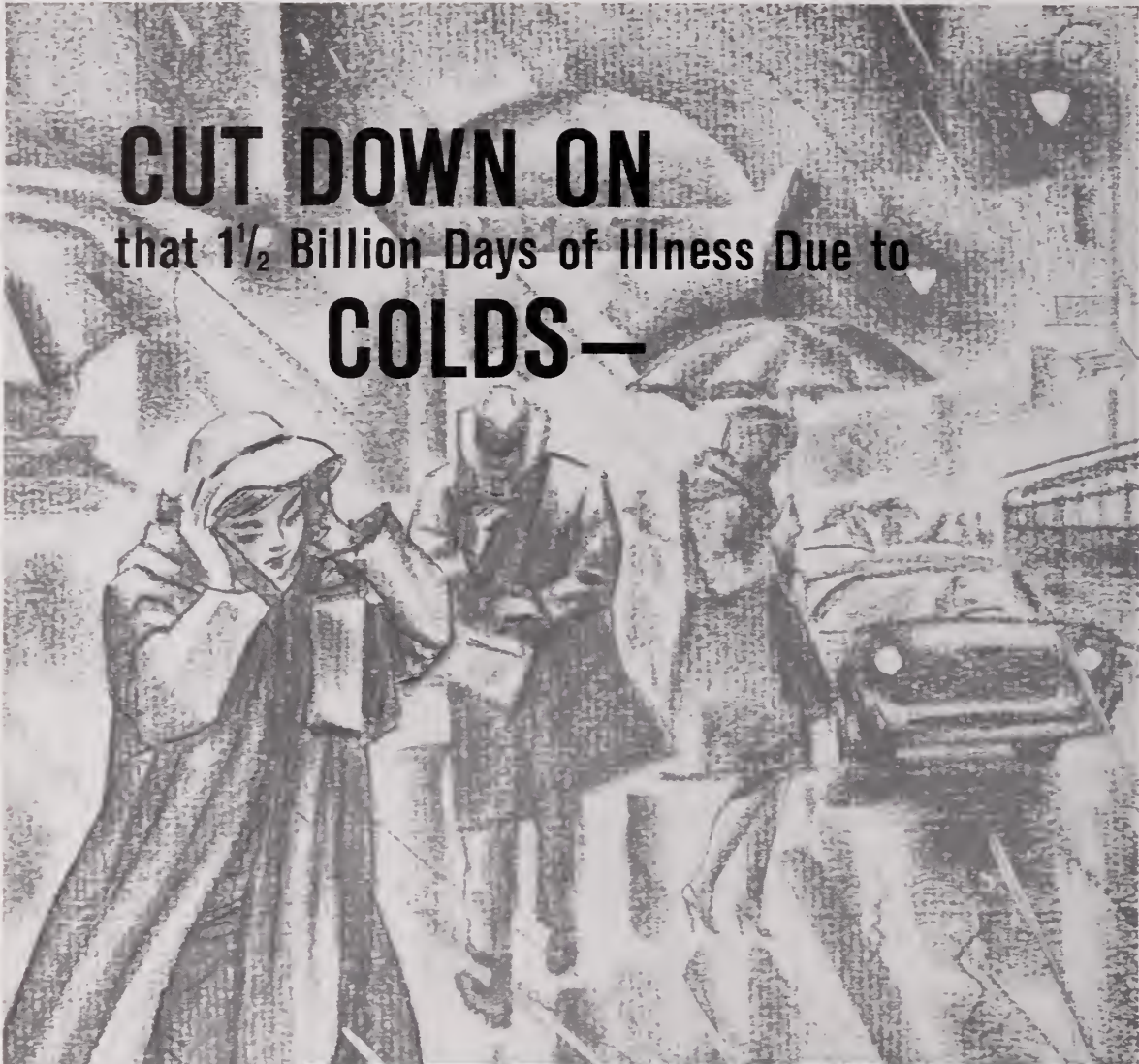
- freedom from salt and water retention
- virtual freedom from potassium depletion
- negligible calcium depletion
- euphoria and depression rare
- no voracious appetite—no excessive weight gain
- low incidence of peptic ulcer
- low incidence of osteoporosis with compression fracture

*Indications:* rheumatoid arthritis; arthritis; respiratory allergies; allergic and inflammatory diseases; disseminated lupus erythematosus; nephrotic syndrome; lymphomas and leukemias. *Contraindications:* With ARISTOCORT all traditional precautions to corticosteroid therapy should be observed. Dosage should always be carefully adjusted to the smallest amount which will suppress the disease. After patients have been on steroids for prolonged periods, discontinuance must be made gradually.

*Dosage:* Scored tablets of 1 mg. (yellow); 2 mg. (pink); 4 mg. (white); 16 mg. (white). Parenteral (for intra-articular and intrasynovial injection). Vials of 5 cc. (25 mg./cc.).

*References:* 1. Feinberg, S.M., Feinberg, A.R., and Fisherman, E.W.: *J.A.M.A.* 167:58 (May 3) 1958. 2. Epstein, J.I. and Sherwood, H.: *Connecticut Med.* 22:322 (Dec.) 1958. 3. Friedlaender, S. and Friedlaender, A.S.: *Antibiotic Med. & Clin. Ther.* 5:315 (May) 1958. 4. Segal, M.S. and Duvenci, J.: *Bull. Tufts North East M. Center* 4:71 (April-June) 1958. 5. Segal, M.S.: Report to the A.M.A. Council on Drugs, *J.A.M.A.* 169:1063 (March 7) 1958. 6. Sherwood, H. and Cooke, R.A.: *J. Allergy* 28:97 (Mar.) 1958. 7. Duke, C.J. and Oviedo, R.: *Antibiotic Med. & Clin. Ther.* 5:710 (Dec.) 1958. 8. McGavack, T.H.: *Clin. Med.* (June) 1958. 9. Freyberg, R.H.; Berntsen, C.A., and Hellman, L.: *Arthritis and Rheumatism* 1:215 (June) 1958. 10. Hartung, E.F.: *J.A.M.A.* 167:973 (June 21) 1958. 11. Hartung, E.F.: *J. Florida Acad. Gen. Pract.* 8:18, 1958. 12. Zuckner, J.; Ramsey, R.H.; Caciolo, C., and Gantner, G.E.: *Ann. Rheum. Dis.* 17:398 (Dec.) 1958. 13. Appel, B.; Tye, M.J., and Leibsohn, E.: *Antibiotic Med. & Clin. Ther.* 5:716 (Dec.) 1958. 14. Kalz, F.: *Canad. M.A.J.* 79:400 (Sept.) 1958. 15. Mullins, J.F., and Wilson, C.J.: *Texas State J. Med.* 54:648 (Sept.) 1958. 16. Shelley, W.B.; Harun, J.S., and Pillsbury, D.M.: *J.A.M.A.* 167:959 (June 21) 1958. 17. DuBois, E.F.: *J.A.M.A.* 167:1590 (July 26) 1958. 18. McGavack, T.H.; Kao, K.T.; Leake, D.A.; Bauer, H.G., and Berger, H.E.: *Am. J. Med. Sc.* 236:720 (Dec.) 1958. 19. Council on Drugs: *J.A.M.A.* 169:257 (Jan. 17) 1959. 20. Rein, C.R.; Fleischmajer, R., and Rosenthal, A.R.: *J.A.M.A.* 165:1821 (Dec. 7) 1957.

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# CUT DOWN ON

that 1½ Billion Days of Illness Due to

# COLDS—

## NEO-SYNEPHRINE<sup>®</sup>

COMPOUND

## COLD TABLETS

*for "Syndromatic" Control of the Common Cold  
and Allergic Rhinitis*

*provide  
PROTECTION—  
through the  
full range of  
cold symptoms*

### PROTECTION from Nasal Stuffiness

— Neo-Synephrine HCl, 5 mg. — first choice in decongestants.

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— Acetaminophen, 150 mg. — modern analgesic, antipyretic.

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— Caffeine, 15 mg. — dependable, mild stimulant.

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DOSAGE: Adults—2 tablets three times daily.

Children from 6 to 12 years—  
1 tablet three times daily.

Bottles of 20 and 100 tablets.

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## Incremin<sup>®</sup> with iron Syrup

Lysine-Vitamins Lederle

**help restore the normal blood picture**—iron as ferric pyrophosphate to restore or maintain normal hemoglobin.

**boost appetite and energy**—vitamins . . . B<sub>1</sub>, B<sub>6</sub> and B<sub>12</sub>.

**upgrade low-grade protein**—cereals and other low protein favorites of children, upgraded by I-Lysine, work with meat and other top protein to build stronger bodies.

**tastes good!** Each daily cherry-flavored teaspoonful dose (5 cc.) contains:

I-Lysine HCl	300 mg.
Vitamin B <sub>12</sub> Crystalline	25 mcgm.
Thiamine HCl (B <sub>1</sub> )	10 mg.
Pyridoxine HCl (B <sub>6</sub> )	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.
Alcohol	0.75%

Bottles of 4 and 16 fl. oz.



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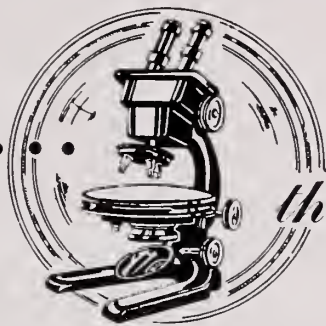


*For Quality without Question... Enjoy the  
unique refreshment of sparkling Coca-Cola*



SIGN OF GOOD TASTE

## THROUGH .

*the Microscope****LIFE Reports on Hospital and Physician Costs***

The next few years will see hospital costs soaring, doctors' fees holding steady, and medical insurance growing until just about all of us are covered for every kind of illness and accident. These predictions, based on extensive interviews with U.S. health officials and physicians, were made by LIFE magazine in the concluding article of its four-part series on the American doctor.

The magazine said that it is probably impossible to reduce the costs of running a hospital but that experts who have studied the problem of skyrocketing prices for hospital care are searching out new paths to efficiency.

In the twenty years from 1936 to 1956 the fees charged by surgeons rose by 60 per cent, those of general practitioners 73 per cent. Neither are considered out of line with general price rises. But during the same period, hospital room rates zoomed 265 per cent, faster than almost anything else the dollar can buy. In most hospitals today, a private room costs about \$25 a day.

The LIFE study showed that hospital costs will continue to rise as the result of being forced, among other things, to pay employees better wages. The magazine pointed out that hospitals traditionally have been among the most relentless exploiters of unskilled labor, paying anywhere from \$10 to \$20 a week less than industry. A hospital strike in New York last spring uncovered the fact that many hospitals were paying their unskilled help weekly salaries of \$33.

Two other reasons for bigger bills are the demands by patients for fancier, better decorated rooms, and the fact that nursing care, laboratory and other technical services, which used to take less than half the hospital dollar, today gobble up almost three fourths of that dollar as new techniques and discoveries enlarge the opportunities for proper medical treatment.

Physician fees will probably remain steady, the magazine said. Doctors never had it so good as they do today. Thanks to a prosperous economy and the

various insurance plans, they now collect more than 90 per cent of their bills, whereas once they were lucky to collect 75 per cent. Because their services are so popular, they have more patients than in former years. Yet they make fewer night calls and spend more weekends with their families.

LIFE reports the experts as predicting continued growth of medical insurance plans until almost the entire citizenry is covered for almost every kind of treatment. The costs will rise as broader types of benefits are included, and this is expected to cause some widespread complaints from those who rebel against spending a sizable sum for protection against illnesses that may never occur.

***Policy of Free Lab Exams Established by Health Department***

During the depression of the thirties, the State Health Department laboratories inaugurated a program of performing diagnostic tests and procedures for the medically indigent, which had little or no public health significance.

Over the years this service has grown, until today the number of procedures performed annually is out of proportion to the number of medically indigent patients. A cursory inspection of records reveals that many procedures are being performed for private physicians on private patients when, in fact, such procedures should be performed by private clinicopathological laboratories.

To overcome this situation the following policy is established effective November 10, 1959:

Laboratory Services will be restricted to:

- (a) The medically indigent;
- (b) patients of department-sponsored clinics;
- (c) occasional disease-detection drives;
- (d) essential services for the control of communicable diseases;
- (e) consultative services to other laboratories and hospitals.

***Public Health Service Reports on Children Disabilities***

The extent to which acute illnesses and injuries—  
*continued on page 834*



when you see  
signs of  
anxiety-tension  
specify

**Dartal<sup>®</sup>** dihydrochloride  
brand of thiopropazate dihydrochloride

*for rapid relief of anxiety manifestations*

You will find Dartal outstandingly beneficial in management of the anxiety-tension states so frequent in hypertensive or menopausal patients. And Dartal is particularly useful in the treatment of anxiety associated with cardiovascular or gastrointestinal disease, or the tension experienced by the obese patient on restricted diet. You can expect consistent results with Dartal in general office practice.

*with low dosage:* Only one 2, 5 or 10 mg. tablet t.i.d. *with relative safety:* Evidence indicates Dartal is not icterogenic.

Clinical reports on Dartal: 1. Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat. 80:481 (Oct.) 1958.  
2. Ferrand, P. T.: Minnesota Med. 41:853 (Dec.) 1958.  
3. Mathews, F. P.: Am. J. Psychiat. 114:1034 (May) 1958.

**SEARLE**



## ATHLETIC INJURIES TO THE UPPER EXTREMITY\*

A. A. SAVASTANO, M.D.

The Author. *A. A. Savastano, M.D., of Providence, Rhode Island. Consulting Orthopedic Surgeon, Department of Athletics, University of Rhode Island, Kingston, Rhode Island.*

**A**THLETIC INJURIES to the upper extremity by and large are no different than those occurring in the same extremity in everyday life; however, there are some injuries which are more apt to occur during participation in sports than in everyday activity.

### *Injuries of the Hand*

The most common injuries to the fingers of athletes are fractures of the bones. The ligaments, tendons, muscles, etc., are also injured but in my personal experience fractures have occurred most commonly. What makes fractures of the fingers so important and sometimes so difficult to treat is the complex anatomical mechanism which makes up the finger. Without going into details, in addition to the ligaments and capsule of the interphalangeal joints, there is the long extensor digitorum communis tendon on the back of the finger, the flexor digitorum profundus and sublimis tendons on the anterior aspect of the finger and then, of course, the neurovascular bundles on the front of each finger. The musculature along the side consists of the lumbricales and the interossei.

Some of the more common injuries affecting the hand are as follows:

**"Buttonhole" Deformity:** This deformity is considered to represent the rupture of the central slip of the extensor tendon at the level of the proximal interphalangeal joint. This injury happens frequently during football contact. Treatment of this deformity is surgical repair with a removable wire suture. The sooner the operation is done after the injury, the better the prognosis.

**Mallet Finger:** This is due to avulsion of the insertion of the extensor tendon from the base of the terminal phalanx. The avulsion may take place with

or without an attached fragment of bone. The cause of this injury is a blow at the tip of the finger, forcing it into acute flexion at a time when the tendon is contracting. Treatment by fixation in plaster with the distal interphalangeal joint in hyperextension and the proximal interphalangeal joint in flexion usually gives a good result. Other methods such as open operation, wire fixation and pin fixation have also been used.

**Fractures of Distal Phalanges:** To return to the actual fractures of the fingers. Fractures of the distal phalanges seldom prove troublesome and unless there is gross displacement, merely splinting the finger suffices. If a very painful subungual hematoma exists, it should be evacuated by trephining a hole through the base of the nail which is done with the red hot end of a paper clip heated with a cigarette lighter, alcohol lamp or even matches. Evacuation always gives immediate relief from the intense pain caused by pressure of the hematoma.

**Fractures of the Middle and Proximal Phalanges:** Fractures in these phalanges very often prove much more troublesome as far as treatment is concerned than do those affecting the distal phalanges. Because of the pull of the tendons, overriding of the fracture is apt to take place. If no overriding or minimal overriding has taken place, mere splinting of the fracture with the interphalangeal joints flexed to 10-15 degrees should suffice; however, if overriding and shortening of the fingers has taken place, it becomes mandatory to try to reduce the fracture. Merely pulling on it and an attempt to hold it with plaster or any other form of immobilization often does not hold the reduction; consequently, my preference is to use skeletal thin Kirschner wire traction. The wire is introduced through the phalanx from side to side depending on the site of the fracture and then applying traction with a rubber band which extends from the Kirschner wire to a coat hanger wire which has been incorporated in a plaster cast. After three weeks of this form of traction, enough healing has usually taken place at the fracture site to allow the traction to be discontinued and motion started. Because of the small amount of

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soft tissue present in the fingers, fractures of the fingers can produce considerable permanent limitation of motion unless motion is started actively at an early stage.

*Metacarpal Fractures:* Fractures of the metacarpals as a rule do not prove to be troublesome because of the fact that nature itself has provided an aid in the splinting of these fractures. By this is meant the presence of other uninjured metacarpals which help to maintain the reduction after it has been accomplished. Fractures of the shaft of the metacarpals and fractures at their base often require very little treatment except splinting by the use of spools, gauze bandage rolls, plaster casts, etc. I will admit, however, that if considerable overriding has taken place, it may occasionally become necessary to do an open reduction. If an open reduction becomes necessary, then intramedullary wire fixation has given me the most desirable results because early function of the hand can be started. The wire is pulled out three to five weeks after it has been inserted.

Fractures at the neck of the metacarpal can prove to be rather troublesome insofar as reduction is concerned, and if not reduced, this type of a fracture may produce limitation of motion at the metacarpophalangeal joint and it may result in a deformity of the hand in that you are unable to see the knuckle of the affected metacarpal. This type of fracture most commonly occurs at the neck of the fourth and fifth metacarpals with the metacarpal head being rotated anteriorly. These fractures can, in most cases, be handled very simply by merely forcing the proximal phalanx of the finger into acute flexion and pushing up dorsally on the finger to derotate the rotated metacarpal head. Maintaining the hand splinted in this position for three weeks will take care of the situation very nicely.

### *Injuries of the Wrist Fractures*

A. *Carpal Scaphoid:* The most common fracture which occurs in the carpal bones of the wrist takes place in the scaphoid bone or navicular if you choose so to call it. I would like to say at this point that most of the fractures of the scaphoid that I have seen in athletes at the University of Rhode Island occurred prior to their coming to Kingston. I see a minimum of seven to eight fresh carpal scaphoid fractures every year — most of which occur in high school boys or in boys playing sandlot sports. This fracture is generally due to a fall on the outstretched hand producing a hyperextension at the wrist. The type of injury which is sustained by means of a fall on the outstretched hand and wrist is dependent upon the age group of the individual. A youngster of 8-12 years of age will sustain an avulsion of the distal radial epiphysis with or without a fracture.

A person of 14 to about 30 will usually sustain a fracture of the scaphoid whereas, the older person will sustain a Colles fracture.

An extremely interesting and important point to make about carpal-scaphoid fractures is that they are probably missed more often than any other fracture. The patient will often present himself complaining of pain in the wrist. On examination he may have some pain on palpation in the anatomical snuff box and Goodwin's sign is positive. X rays taken at the time of the fracture may be entirely negative, with the result that one may be led into false security and treat the fracture as a sprain. However, these same wrists, if X rayed 10-14 days later, will show a definite line through the scaphoid due to absorption of bone at the fracture site. Undisplaced fractures of the carpal scaphoid are treated merely by lengthy immobilization. Plaster cast fixation for a minimum of about 15 weeks usually suffices. The wrist is put up in a cock-up position and the plaster cast extends from the distal palmar fold to the junction of the middle and upper third of the forearm. The thumb may or may not be included in the cast. I do not believe that immobilization of the thumb will play any part in the healing of the fracture. A good rule to follow is that you must treat all so-called sprains of the wrist as fractured scaphoids until you prove otherwise.

No matter how well or how long you treat these fractures, you will get a certain number of non-unions.

Now, as to the treatment of an established non-union of a fracture of the carpal scaphoid, opinion varies as to the ideal method. Personally, if both segments of the fracture are of about the same size and no aseptic necrosis exists, I do a bone graft and at the same time remove the radial styloid process. I have been quite satisfied with this form of treatment and until somebody proves to me that his method gives a better result in a shorter period of time, I will continue to use this form of treatment. If one of the fragments is quite small but both fragments are viable or there is an aseptic necrosis of one of the segments of the fracture, then removal of the smaller viable fragment or removal of the aseptic fragment together with styloidectomy of the radius is the treatment which I have followed in recent years.

*Lunate Bone:* The next most commonly fractured carpal bone is the lunate, but this occurs not nearly as often as does the fracture of the scaphoid. In addition to the fracture this bone also not uncommonly becomes dislocated anteriorly. Treatment for the dislocation consists in reduction of the bone under general anesthesia and plaster cast immobilization. If a simple fracture exists, plaster cast immobilization should suffice. A minimum of approximately ten weeks' immobilization is necessary.



Fractures of the remaining carpal bones occur so infrequently that it is not worthwhile spending any time on them at present.

### *Injuries of the Forearm*

*Fractures of the Forearm:* Fractures of the bones of the forearm are difficult to treat particularly when overriding exists. If the position is good, simple immobilization in a plaster cast with the cast extending beyond the wrist and above the elbow suffices. However, if overriding of the fracture takes place, it becomes very difficult to reduce it. If only one of the bones is fractured, you have difficulty in reducing the fracture because the intact bone prevents you from getting the necessary pull or leverage or both to reduce it. Because of this, a large number of fractures of the bones of the forearm require open reduction. I personally like intramedullary fixation and at the same time I do a bone graft by either placing autogenous bone or bone bank bone at the fracture site. If bone grafting is done at the time of the open reduction, you will find that healing is more rapid and the number of failures is reduced. Long-term immobilization of the fracture is not necessary when intramedullary fixation is used.

Fractures of both bones of the forearm of youngsters whose distal radial and ulnar epiphyses are not closed do not pose the problem that is presented once the epiphyses have become closed. In other words, even if the fractured segments are not in ideal apposition, you will generally get satisfactory healing if the epiphyses are still open.

*Soft Tissue Injuries of the Forearm:* Contusions of the forearm are common in football players. These are treated with cold applications in the early stages and heat after the first 24-48 hours.

Abrasions of the forearm are treated by cleaning, application of antiseptics and dressings as necessary. A strain of the pronator radii teres which occurs in a good many baseball pitchers is the result, I am told, of throwing the so-called screwball and will respond to rest which consists in essentially non-throwing together with the application of heat. If the pitcher continues to be plagued by this type of trouble, it becomes mandatory for him to change his type of delivery if he is to remain active as a pitcher.

### *Injuries of the Elbow*

*Olecranon Bursitis:* Olecranon bursitis is usually traumatic, being due to either blows or falls on the tip of the elbow. This is treated by aspiration and local injections of hyaluronidase or hydrocortisone or both and the application of pressure with ace bandages. I have never had to excise a traumatic olecranon bursa in an athlete.

*Tennis Elbow:* This is a commonly used term which may mean a medial or lateral epicondylitis as

well as a radiohumeral bursitis. If the condition is due to an actual epicondylitis, there is usually a fraying of the origin of the extensor mechanism at the lateral epicondyle or a fraying of the flexors at the internal epicondyle. These patients will complain of pain either on the medial or on the lateral side of the elbow as the case may be. If the thumb is placed over the radial head and the forearm is rotated, the patient will generally complain of severe pain underneath the examining thumb over the radial head. Many forms of treatment have been used in these cases and have consisted of rest, heat and local injections with procaine, xylocaine, hyaluronidase and hydrocortisone or any combination of these medications. A high percentage of these cases are improved by the injections. The stubborn cases may need surgery which may consist of cutting the offending attachment and closing the wound. This type of operation is not always successful. Other types of operations which have been done on these cases consist of cutting the orbicular ligament around the head of the radius which is thought by some to be causing bursitis or actually causing a pinching of synovial tissue. In the real stubborn cases, Emanuel Kaplan in New York has been cutting the sensory branches of the radial nerve with encouraging results. I myself have done one such case with a very, very gratifying result.

*Contusions of the Elbow:* Blows or forced hypermotion of the elbow may cause synovial or ligamentous injuries with resulting bleeding in the elbow joint or the formation of excessive synovial fluid. These are best treated by aspiration of the excessive fluid and the introduction of hydrocortisone or hyaluronidase into the joint or the introduction of a combination of both. This should be followed by compression for a period of 24-48 hours with an ace bandage.

*Fractures of the Radial Head:* This is probably the most common fracture which occurs in an athlete's elbow. I like to classify fractures of the head of the radius into essentially four types:

*Type 1*—This is the fracture which occurs through the neck without injuring the head and generally causes the entire neck and head to be tilted laterally. These I like to treat by making an attempt at closed reduction. With the patient under general anesthesia, the elbow is adducted and with the thumb pressure is made on the radial head upward and inward in an attempt to reduce the tilted head and neck. This is a fracture which occurs mostly in youngsters and this type of manipulative attempt generally produces satisfactory results. If manipulation is unsuccessful, open reduction may become necessary.

*Type 2*—Linear undisplaced fracture of the radial head. Treatment in these cases consists merely of immobilization of the elbow in a plaster

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cast for approximately three weeks and then starting gentle motion. These types of fractures generally give a fine result.

*Type 3* — This is the type in which a piece breaks off the radial head in a person whose epiphysis has closed. Sometimes it is difficult to decide exactly what to do for these patients, but in the long run I think it wise to open the elbow, remove only the fragment and close the surgical wound. By doing this you will, of course, expose the person to a probable traumatic arthritis in his elbow at a later date but you will prevent him from getting pain in his wrist, because when you do remove the radial head, the radius begins receding upwards so as to reduce pain in the wrist. This type of operation, I am told, was done in the case of Ted Williams.

*Type 4* — This is the fracture which is comminuted with pieces breaking and going in every direction. In this type of case, the obvious thing to do is to operate and remove all of the fractured segments and smooth out the proximal portion of the remaining radius. In some cases, attempts have been made to replace the comminuted removed fractured head of the radius with vitallium but this has not proved of much value; consequently, it is not advised, particularly in athletes where movement of the elbow is to be precise, if the athlete is to be of any value as an athlete.

*Fracture of the Olecranon:* This is not an uncommon injury and may be due to a fall on the tip of the elbow. If the fracture is a crack type of fracture or one which is quite definite but in good position, immobilization of the elbow in extension for a few weeks generally suffices. If separation has taken place, then open reduction with metallic fixation becomes necessary.

*Fractures of Coronoid of the Ulna:* If the fragment is small, no particular treatment is necessary other than bandaging and use of a sling for about two weeks, but if the fragment is large, excision by open reduction of the fractured fragment becomes necessary.

*Dislocations of the Elbow:* Dislocations of the elbow may occur as simple anteroposterior dislocations or they may occur together with fractures. The fracture may consist of an avulsion type of fracture, or the lateral and medial components of the joint may break off. The important thing in dislocations of the elbow is to reduce them early. The earlier the reduction, the better the end result. Whether or not you inject hyaluronidase or hydrocortisone or a combination of both into the joint following the reduction is a personal matter. I believe that these adjuncts are of value in reducing either the degree or the number of cases of myositis ossificans which follow these types of injuries. If the dislocation is simple and the reduction is satis-

factory, simple immobilization of the elbow in a posterior plaster splint and ace bandages together with a sling will often suffice; however, if fractures are present then one must not only deal with the dislocation but must also deal with the fracture and in many instances open operation for the fixation of the fracture becomes necessary.

*Chronic Hyperextension Injuries of the Elbow:* These types of injuries are generally due to a relaxation of the anterior soft tissue components of the elbow joint and as a rule do not cause any disability. The treatment consists of taping the elbow prior to the athlete's going into action so that further hyperextension becomes checked.

### *Injuries of the Upper Arm*

*Bicipital Tendinitis:* This injury is usually encountered in baseball players and is due to an irritation of the long head of the biceps in the bicipital groove. Pitchers are more apt to develop this type of lesion than any other athlete. These cases respond to local heat and rest. Injection of hyaluronidase, xylocaine and hydrocortisone occasionally produces very gratifying results. Occasionally the transverse humeral ligament and the tendon sheath may have to be sectioned surgically to obtain relief. Another lesion which is met in baseball players and again usually in pitchers is the slipping of the tendon of the long head of the biceps over the sides of the bicipital groove during the course of throwing. This causes a fraying of the tendon. Treatment of this type of lesion is often very difficult and one should not resort to surgery until every other form of conservative treatment has failed.

*Fractures of the Humerus:* There are no special fractures that take place in the humerus of athletes. Fractures through the surgical or anatomical neck if impacted are best and most simply treated by means of immobilization of the shoulder with a Valpeau bandage. Fractures of the shaft of the humerus are varied and the type of treatment to be instituted depends upon the type of fracture which has been encountered. A transverse fracture of the shaft if in good position needs merely to be immobilized by means of a long sugar-tong plaster cast. If overriding is present, traction becomes necessary. A hanging type of cast is often used by men, and I must confess that I have used it myself with satisfactory results. Fractures through the condylar area of the humerus may be treated by simple immobilization, traction or by operation as the case may dictate.

### *Injuries of the Shoulder*

*Contusions of the Shoulder:* "Shoulder Pointer" in athletic parlance consists of contusions of the tip of the acromion and adjacent structures. These are sustained by direct force on the tip of the shoulder

or by this area being kneed. These lesions generally respond to physiotherapy.

*Shoulder Strain:* This generally designates a straining injury to the internal rotator cuff. The strain may be direct or indirect. Indirect pulling causes an impingement of the rotator cuff between the humeral head of the acromion. Direct injury may be caused by a fall on the shoulder or severe pulling on the arm. These lesions generally respond to rest and physiotherapy, unless a complete tear has taken place in which case the treatment becomes surgical.

*Dead Arm:* There are certain athletes who while playing receive a blow on top of the shoulder and say that they cannot use their arm. The arm goes dead, and this actually does happen. Other boys may complain of numbness of the arm with weakness. This lesion is due to a blow on segments of the brachial plexus which is responsible for the temporary inability to use the arm. Direct injury to the axillary nerve may also occur. These boys may sustain this type of injury several times during a season. The wearing of a large sponge foam rubber horse collar has largely reduced the incidence of this type of injury.

*Acute Dislocation of the Shoulder:* The vast majority of dislocations of the shoulders which take place in athletes are of the anterior variety. I have never seen a posterior dislocation in an athlete either on the high school or college level in the state of Rhode Island. The dislocation generally takes place as a simple dislocation but not infrequently, the greater tuberosity is fractured.

In dislocations of the shoulder there is one word of caution and that is to examine the arm before you start treatment. Injuries to the radial, medial and ulnar nerves are not uncommon at the time of the dislocation.

If you manipulate the shoulder without knowing that nerve injury had taken place, you will probably be blamed for the nerve injury.

I am of the opinion that the vast majority of simple dislocations of the shoulder can be reduced without anesthesia. In these cases, the patient is given an appropriate hypodermic injection of demerol or morphine and a gentle reduction is attempted and works in most cases. I have largely used the Kocher maneuver. One method which is used by some men consists of having the patient lie face-down on the edge of the table with the arm of his dislocated shoulder hanging down and with a ten to twelve pound weight hanging at the wrist. Traction for 10-20 minutes by this method generally produces gratifying results. If one is unable to reduce the fracture by these very simple means, then reduction under general anesthesia becomes indicated. The post-reduction treatment consists of

immobilization of the shoulder by means of a Valpeau splint for a period of approximately three weeks. I think that it is absolutely important to keep the shoulder immobilized for a period of three weeks in order to give the rent or tear in the capsule in the shoulder joint an opportunity to heal before the shoulder begins to be moved about. If this form of treatment is used in dislocations occurring for the first time, the incidence of recurrent dislocations will be diminished.

*Recurrent Dislocations of the Shoulder:* If you have a boy who is constantly re-dislocating his shoulder, the treatment becomes operative. There are many forms of operative treatments which are used. The ones which are most popular consist of doing a so-called Putti-Platt procedure or a Bankart. I personally do the Nicola operation which consists of passing the long head of the biceps through the humeral head. I had the privilege and pleasure of having spent two of my orthopedic residency years with Doctor Nicola and during that time learned the tricks of doing the operation from its originator and, therefore, with few exceptions have used the Nicola operation for recurrent dislocations of the shoulder, with good results. You may ask, how many dislocations should one have before you can call it a recurrent dislocation? I do not know nor do I know of anybody who has it down to a number. Suffice it to say, however, that if a shoulder dislocates without too much provocation and keeps doing it then you are justified in calling it a recurrent dislocation.

*Acromioclavicular Injuries: (Joint Separation)* Dislocations or subluxations of the acromioclavicular joints of athletes in my experience occur more often than do dislocated shoulders. The dislocation takes place as a result of the tearing of the acromioclavicular or the coracoclavicular ligaments or both. Many forms of treatment have been used to take care of these types of injuries. The treatment which is the most popular is to place a piece of felt or thick sponge foam rubber over the clavicle and to strap it down over the shoulder and then to put semi-circular pieces of adhesive around the lower portion of the body to hold these pieces together. Another method which is not used very often, but which I think to be quite good is to apply a body plaster cast and then apply a sling over the clavicle attached to the upper edge of the plaster cast with the body plaster cast acting as a weight in keeping the joint reduced. The weight of the cast reduces the joint. This hanging cast is the same principle used in the treatment of a fractured humerus. There are many other methods of treatment used in the treatment of these dislocations. Surgical treatment includes actual attempts at reconstructing the ligaments with fascia, wiring, metallic intramedullary fixation and excision of part of the clavicle. Some



## TRANSIENT T-WAVE INVERSION AFTER PAROXYSMAL VENTRICULAR TACHYCARDIA IN NORMAL ADULT HEARTS\*

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**P**AROXYSMAL VENTRICULAR TACHYCARDIA is usually a serious disorder of rhythm associated with severe coronary artery disease. It is occasionally observed in association with rheumatic heart disease, hypertensive cardiovascular disease and with the administration of various drugs, such as Digitalis and Pronestyl. Uncommonly it occurs in patients with no heart disease. This report was prompted by the recent observation of a case of paroxysmal ventricular tachycardia in a young female with no apparent heart disease and with impressive transient T-wave inversion following the attack. A review of our Heart Station files from 1946 through July 1958 produced 47 cases of paroxysmal ventricular tachycardia. Of these 47 cases, 41 or 85% were associated with coronary artery disease and only 2 or 4% were found in normal hearts. One case was associated with congenital heart disease (tetralogy of Fallot), two with rheumatic heart disease and one with epidermoid carcinoma of the cervix with metastases to the right ventricle.<sup>1</sup>

TABLE I

47 Patients with Paroxysmal Ventricular Tachycardia  
— 1946-1958

Type of Heart Disease	No. of Patients	Ages
Coronary Artery Disease.....	41 (85%)	42-82
Rheumatic Heart Disease.....	2 (4%)	40-54
No Heart Disease.....	2 (4%)	26-29
Miscellaneous Group		
1. Tetralogy of Fallot.....	1	30
2. Ca of Cervix with Metastases to Heart.....	1	33

### Case 1

This twenty-nine-year-old white, married female gave a history of paroxysmal tachycardia occurring approximately every six months since the age of eighteen. There was no history of rheumatic fever, hypertension or other significant illness. She

\*From the Heart Station, Rhode Island Hospital. Dr. Karas was supported in part by a Fellowship from the Rhode Island Heart Association.

smoked two packs of cigarettes a day. Before her admission to Rhode Island Hospital (July 1958), her last attack, six months previously, was successfully terminated with intravenous Neo-Synephrine. Quinidine had been tried in the past without avail. Following the attack six months ago the patient was placed on Digoxin 0.5 mgm. p.o. daily. This medication she took for four months, discontinuing it because of nausea and vomiting. On her present admission she complained of palpitation, dyspnea, chest pain and anxiety. 0.5 mgm. Neo-Synephrine was given I.V. the night before without success. On admission her blood pressure was 95 to 80/60. The apical heart rate was 210 and regular. The patient appeared extremely apprehensive, complaining of anterior chest pain. Examination was not remarkable except for her tachycardia with slight variation in the intensity of the first heart sound at the apex. Her laboratory data, including hemoglobin, white blood count, B.U.N. and cholesterol,

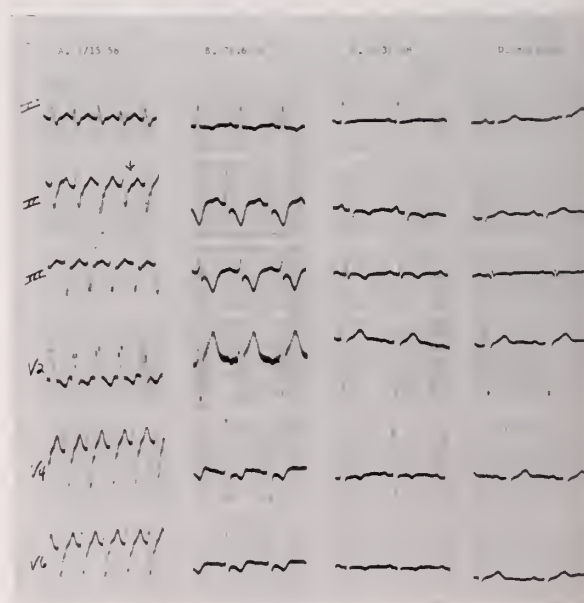


FIGURE 1

- Ventricular tachycardia, rate 190. In portions of Leads II and III independent auricular activity at a rate of 65 could be identified.
- Normal sinus rhythm, rate 104. Inverted T waves in all limb leads, most striking in Leads II and III.
- Less inversion of T waves.
- Return to normal.



were normal. She remained afebrile during her stay.

There was no response to carotid sinus pressure, 1000 mgm. intravenous Pronestyl and 1.0 mgm. Neo-Synephrine, but sinus rhythm reappeared three hours after the administration of 1.6 mgm. of Cedilanid I.V. with prompt relief of chest pain and weakness. She was then digitalized slowly with Digitoxin and thereafter was placed on 0.1 gm. of Digitalis leaf five days per week. The duration of her attack was about forty hours. Following her conversion, typical post-tachycardia T-wave inversion was noted. These changes persisted for at least fifteen days but an electrocardiogram taken thirty-six days after her tachycardia showed normal T waves in all leads (Figure 1).

### Case 2

A twenty-six-year-old white male sales engineer was first seen by one of us (F.C.) in October 1954 a few days following a bout of rapid heart action which began while he was lifting a boulder. The first episode occurred in 1947 at age nineteen, with an average of one attack per year. Each episode was associated with vague anterior chest pain, dyspnea and prostration. There was no history of hypertension or rheumatic fever and he was a nonsmoker. Physical exam: Pulse 76, B.P. 120/70, weight 185. The patient was a rugged athletic young man. Complete examination was negative, including chest fluoroscopy.

He had another short attack in June 1955 with reversion after 0.4 gm. Quinidine and another longer one in July 1955. Vasoxyl was tried, 10 mgm. I.V. and 1 M., without effect. Several doses of Quinidine given p.o. were followed by reversion to slow sinus rhythm after 14 hours. He was advised to take prophylactic Quinidine, 0.2 gm. p.o., prior to any anticipated vigorous exercise. No attacks have occurred from July 1955 through January 1959 (Figure 2).

### Discussion

One of the earliest case reports on T-wave inversion following a bout of paroxysmal ventricular tachycardia was in 1931 by McMillan and Bellet.<sup>2</sup> Their patient, a sixteen-year-old pregnant girl with a normal heart, had a Caesarean section at term with a tachycardia of 150. She converted with Quinidine, following which she had inverted T waves in leads II and III. Graybiel & White<sup>3</sup> (1934) described inversion of T waves which gradually returned to normal following an attack of persistent paroxysmal tachycardia. In 1942, Campbell<sup>4</sup> and Currie<sup>5</sup> separately reported transient T-wave inversion after bouts of paroxysmal tachycardia. Campbell presented three cases between the ages of seventeen and twenty-one with paroxysmal tachycardia. He concluded that after a long paroxysmal tachycardia the T waves may become inverted in one or more

leads for some days. He felt that this did not indicate organic disease but is a completely reversible process, suggesting some degree of exhaustion or strain of the heart muscle.

In 1943 Cooke and White<sup>6</sup> reviewed 27 cases of paroxysmal ventricular tachycardia. Four of their cases had normal hearts; however, no mention was made of post-tachycardia T-wave changes. In an excellent paper on paroxysmal ventricular tachycardia, Armbrust and Levine<sup>7</sup> in 1950 analyzed 107 cases. Thirteen patients (12%) had no heart disease. For this group, prognosis was excellent. Post-tachycardia T-wave changes were not described in their report. However, Levine,<sup>8</sup> in his latest edition of CLINICAL HEART DISEASE, describes transient inversion of T waves occasionally following any attack of paroxysmal rapid heart action. Smith<sup>9</sup> in 1946 reported a case of repeated episodes of paroxysmal ventricular tachycardia where the T-wave changes persisted from six to sixty days. As he indicated, the mechanism of the post-tachycardia pattern is not known but is not indicative of cardiac disease. In the abstracts of the scientific sessions of the American Heart Association, 1958, Hermann<sup>10</sup> reported on a ten-year study of paroxysmal ven-

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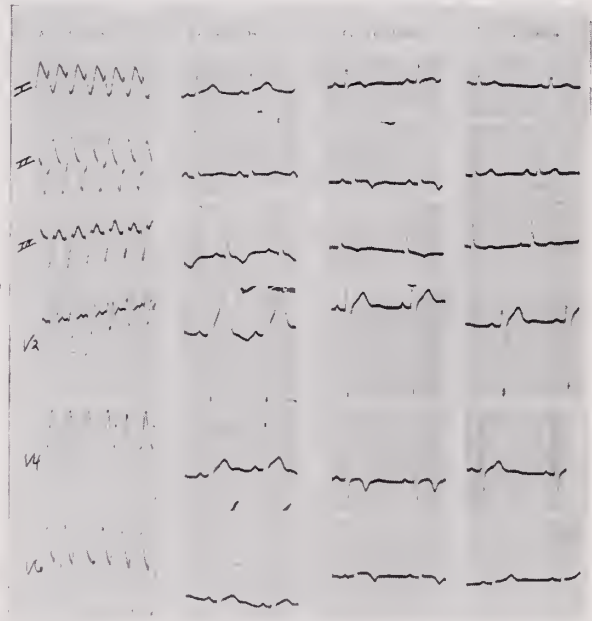


FIGURE 2

- A. Ventricular tachycardia, rate regular at 225. Independent auricular activity cannot be identified.
- B. Normal sinus rhythm. Slight S-T interval elevation in Leads I and II and chest leads, suggesting epicardial damage.
- C. S-T intervals are now nearly normal. Late T-wave inversion in limb leads and V-4 and V-6.
- D. The tracing has now returned to normal. Three electrocardiograms taken subsequently, June 23, 1955, November 27, 1956 and January 26, 1959, were identical.

tricular tachycardia. Six of their fifty-nine patients (or 10%) had no organic heart disease. However, no mention of transient T-wave inversion was made.

Our two cases were alike in several respects. The two young patients had a heart rate around 200, considerable chest discomfort, dyspnea and anxiety and were severely disabled during their attacks. Both had transient T-wave inversion following the attack and both have remained entirely well to date.

It is of interest that in Case 2 the tracing showed moderate elevation of the ST interval in leads I and V-4 which subsequently disappeared. The duration of the T-wave inversion was at least fifteen days in Case 1 and seven days in Case 2 without any change in the QRS complexes. These sequential alterations in the ST intervals and T waves are quite similar to those observed in pericarditis and suggest that the area of injury was epicardial in location. Its actual mechanism is, however, obscure.

### SUMMARY

Two patients with paroxysmal ventricular tachycardia and post-tachycardia T-wave inversion in normal hearts are presented. A review of some of the pertinent literature on this subject would suggest that this sequence is uncommon. As has been pointed out, the prognosis is usually excellent in those patients without other evidence of heart disease.

We are indebted to Doctor Jacob Stone for permission to study Case 1.

### REFERENCES

- <sup>1</sup>Dross, R.L.; and Cutts, F.B.: "Myocardial metastases from carcinoma of the cervix with ventricular tachycardia and sudden death," *Southern Med. Journal* 42: 1040-1043 (Dec.), 1949
- <sup>2</sup>McMillan, T.M.; and Bellet, S.: "PVT"; Report of a case in a pregnant girl with an apparently normal heart." *Am. Ht. Journal* 7:70-78 (Oct.), 1931-1932
- <sup>3</sup>Graybiel, A.; White, P.D.: "Inversion of the T wave in Lead I or II of the electrocardiogram in young individuals with neuro-circulatory asthenia, with thyrotoxicosis in relation to certain infections and following paroxysmal ventricular tachycardia." *Am. Ht. Journal* 10: 345-354 (Feb.), 1934-1935
- <sup>4</sup>Campbell, M.: "Inversion of T waves after long paroxysms of tachycardia." *British Ht. Journal* 4: 49-56 (Jan.-April), 1942
- <sup>5</sup>Currie, G.M.: "Transient inverted T waves after paroxysmal tachycardia." *British Ht. Journal* 4: 149-152 (Oct.), 1942
- <sup>6</sup>Cooke, W.T.; White, P.D.: "Paroxysmal ventricular tachycardia." *British Ht. Journal* 5: 33-54 (Jan.), 1943
- <sup>7</sup>Armbrust, C.A.; Levine, S.A.: "PVT; A study of 107 cases." *Circulation* 1: 28-40 (Jan.), 1950
- <sup>8</sup>Levine, S.A.: "Clinical heart disease." W.B. Saunders Co., P. 527, 1958
- <sup>9</sup>Smith, L.B., Lt. Col. MC: "PVT followed by electrocardiographic syndrome." *Am. Ht. Journal* 32: 257-260 (Aug.), 1947
- <sup>10</sup>Hermann, G.R., et al: "Paroxysmal ventricular tachycardia — a ten-year study." *Circulation* 18 (Part 2): 735 (Oct.), 1958

### ATHLETIC INJURIES TO THE UPPER EXTREMITY

*concluded from page 811*

years ago, Boardman Bosworth reported some cases in which he put a screw through the clavicle into the coracoid process. This has not proven to be a popular method as it fixes the coracoid to the clavicle which is not desirable because normally there is motion between these two bones and the fixation of them together with a screw may cause one or the other to give, resulting in a fracture.

Other forms of treatment which have been used have consisted of passing wires across the acromioclavicular joint and removing them a few weeks later. One must be extremely careful when one uses wires as wires not infrequently migrate into the soft tissues and some have been reported to have migrated into the lungs.

Doctor Moseley of Canada recommends excising the outer centimeter or two of the clavicle and putting a heavy silk suture through a hole in the clavicle, threading it through the ruptured ligaments and then carrying it back and forth on the clavicle two or three times. This, in his hands, has given very excellent results. I have used this type of treatment and can vouch for the results that he reports.

### *Sternoclavicular Dislocations*

This is a rather uncommon type of injury but it does occur. These are extremely difficult to reduce and to keep reduced. In the acute phase, the placing of a sandbag between the shoulder blades and producing the stick-your-chest-out position may reduce the dislocation. It may then be held reduced by means of Fig. 8 bandages around the shoulders. If this does not prove of value, open reduction with wire fixation or even resection of the proximal portion of the clavicle may become indicated.

### *Fractures of the Clavicle*

In the average fracture, putting the shoulders outward and backward and holding them with Fig. 8 bandages or any method that you like best usually suffices. If the fracture is markedly overriding, one may try manipulating the fracture under local anesthesia by grasping each fractured end of the clavicle with towel clips and manipulating the fracture. This will work only if you have transverse fractures. I have personally not cared for fixation by plaster casts as it is a rather cumbersome and annoying type of immobilization to the patient. Practically all fractured clavicles heal. If your patient is not concerned about the bump that the fracture may leave as a result of excessive callus formation, open reduction need not be done; however, there are cases where for some reason or other open surgery becomes necessary. In these cases, the insertion of metallic pins can be used. Some men prefer to use wire fixation; however, we feel that intramedullary fixation gives a much more stable type of immobilization.



## TENSION PNEUMOTHORAX IN A NEWBORN INFANT

ROBERT M. LORD, JR., M.D. AND LESTER L. VARGAS, M.D.

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**T**ENSION PNEUMOTHORAX in the newborn infant occurring immediately following delivery is an uncommon but urgent problem. Impaired ventilation together with altered cardiovascular dynamics may rapidly result in death. If these infants are to be saved, the condition must be suspected whenever respiratory distress is present at birth or in the immediate neonatal period. The diagnosis should be confirmed by chest X ray or needle aspiration if X ray is not immediately available. The following case report illustrates the features of this serious complication of the postpartum infant.

S.T. (R.I.H. 590615) was a full-term white male infant born to a twenty-eight-year-old gravida I para I mother by Cesarean section because of cephalopelvic disproportion at the Providence Lying-In Hospital on February 20, 1958. The mother's membranes had ruptured spontaneously 17½ hours before delivery. Resuscitation with the aid of positive pressure breathing devices was not employed.

Physical examination at birth revealed a well-developed white male infant who was completely flaccid and unresponsive. Birth weight was 7 lbs. 13 oz. Respirations were gasping and cyanosis persisted despite the administration of oxygen in an incubator. No obstruction of the larynx or trachea was found. The trachea was in the midline. Heart sounds were of good quality and the rhythm was regular. Breath sounds were completely absent over both lung fields. Roentgenographic examination of the chest one hour after delivery showed a collapse of the left lung with a pneumothorax (Figure 1) together with a very small amount of air in the right pleural space.

Aspiration of the left pleural cavity was performed immediately and yielded 1,000 cc. of air under pressure. Although the infant was dramatically relieved of dyspnea by this procedure, hyperresonance and diminished breath sounds persisted over the left hemithorax. However, normal breath sounds were heard over the right lung field. The fact that an inordinately large amount of air had

*concluded on next page*



FIGURE 1



FIGURE 2



been removed suggested a persistent air leak into the left pleural space. Accordingly, the infant was transferred to the Rhode Island Hospital where a closed thoracotomy was performed. The infant's subsequent course was uneventful. Follow-up chest X rays (Figure 2) revealed no pneumothorax but a partial atelectasis of the left upper lobe which finally cleared. The chest catheter was removed after five days and he was discharged on his eighteenth hospital day.

### Discussion

The pathogenesis of pneumothorax in the first few hours of life is not well understood. Macklin and Macklin<sup>1</sup> have suggested that air escapes from overdistended alveoli into the interstitial tissues of the lungs. Atelectasis of a portion of the lung from any cause frequently is associated with compensatory over-distention of alveoli in the adjacent normal lung tissue. Air escaping by this mechanism dissects along the perivascular sheaths in the interstitial tissues of the lung to the mediastinum. The air is moved toward the mediastinum by the normal lengthening and shortening of the bronchi which occurs during respiration. A tension mediastinum results. Air in the mediastinum ruptures into the pleural space.

Vigorous efforts to expand the infant's lungs at delivery or spontaneous rupture of pleural blebs undoubtedly account for a few cases, but in the majority of reported patients studied at autopsy pleural tears are rarely found. Emery<sup>2</sup> reported fourteen infants who had succumbed with pneumothorax following delivery and was unable to find any evidence of visceral pleural tears. In a series of ten patients studied by Harris<sup>3</sup> only two instances of pneumothorax were considered to be remotely associated with vigorous efforts at resuscitation.

Abnormal delivery is a possible etiologic factor and may have played a part in the patient reported above who was delivered by Cesarean section 17½ hours after spontaneous rupture of the membranes. Of eleven<sup>4-6</sup> previously reported cases the following abnormalities were noted: three Cesarean sections, one face presentation, one abruptio placenta, two precipitous labors, and one premature twin. On the other hand, all of Emery's<sup>2</sup> fourteen patients had had normal deliveries.

The treatment of spontaneous tension pneumothorax must be considered in any newborn suffering from severe respiratory distress. Effective emergency treatment should not be delayed because typical signs of pneumothorax are not elicited by careful physical examination. When impairment in pulmonary ventilation poses an immediate threat to life, prompt needle aspiration of one or both pleural spaces should be performed by the physician in attendance at the time. This procedure can be life

saving when a tension pneumothorax exists and similarly large congenital pulmonary cysts can be temporarily decompressed until a definite diagnosis can be made by chest X ray. In our experience, thoracentesis has not altered the clinical course of moribund newborn babies with respiratory distress resulting from large congenital diaphragmatic herniae. The objection to perforating a herniated viscus hardly seems valid when these desperately sick infants rarely survive long enough to be operated on.

While needle aspiration of the pleural space usually affords dramatic relief to the exhausted infant, continued air leakage is common, as was the case in the patient reported above. For this reason, it is essential to establish full expansion of the relatively less compliant infant lung by closed thoracotomy with suction drainage. A small (#12F) rubber catheter is introduced through the 7th interspace in the anterior-axillary line with the aid of a suitable trocar and local (1% procaine) anesthesia. The catheter is connected through rigid tubing to a water seal bottle which in turn is attached to any suitable system maintaining a negative pressure of from -8 to -10 cm. of water. Persistent air leakage in the pleural space is manifested by continued bubbling in the water seal bottle. This usually ceases after 24 to 48 hours and the chest catheter can be removed.

### SUMMARY

1. A newborn infant with massive left sided pneumothorax is presented.
2. Diagnosis is accurately made by chest X ray.
3. If chest X ray cannot be obtained immediately, needle aspiration of pleural space should be performed to establish the correct diagnosis and alleviate respiratory distress in the most seriously ill infants.
4. The only safe treatment of massive pneumothorax in the newborn infant is closed thoracotomy.

### BIBLIOGRAPHY

- <sup>1</sup>Macklin, M. T., and Macklin, C. C.: Malignant Interstitial Emphysema of the Lungs and Mediastinum. *Medicine* 23:281, 1944
- <sup>2</sup>Emery, J. L.: Interstitial Emphysema, Pneumothorax and Air Block in Newborn. *Lancet* 1:405, 1956
- <sup>3</sup>Harris, L. E.: Pneumothorax in the Newborn Infant. *Proc. of the Staff of Mayo Clinic* 30:297, 1955
- <sup>4</sup>Howie, V. M., and Weed, A. S.: Spontaneous Pneumothorax in Newborn. *J. Pediat.* 50:6, 1957
- <sup>5</sup>Strain, J. E., and Connell, J. R.: Pneumothorax in Newborn. *J. Pediat.* 36:495, 1950
- <sup>6</sup>Borne, S.; Mercado, O., and Holzager, I. C.: Airblock in a Premature Infant. *New York J. Med.* 55:1347, 1955

### PROVIDENCE MEDICAL ASSOCIATION

#### 113th Annual Meeting

Monday, January 4, 1960, at 8:30 P.M.

## UNILATERAL RENAL DISEASE WITH HYPERTENSION\*

## A Case Study

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THE RENAL hypertensive syndrome has received a great deal of attention in the recent medical literature.<sup>1,2</sup> In the last twenty-five years, many clinical studies have attempted to correlate the relationship of renal disease to the problem of hypertension in general. Although the role of renal disease in the etiology of so-called "essential hypertension" has yet to be demonstrated, well documented instances of curable hypertension secondary to unilateral renal pathology have been reported. The following is such a case.

*Case Report*

L.L., a forty-two-year-old white male, was admitted to the U.S. Naval Hospital, Newport, Rhode Island, with a cough, headache, and a pulmonary infiltrate. He was in good health until three months prior to admission when he first noted the insidious onset of progressive fatigue and weakness. In the ensuing weeks he developed intermittent fleeting nocturia and polyuria. Three weeks prior to admission, he developed frontal headaches with progressive weight loss. Shortly thereafter, he developed a dry, hacking cough. An X ray (Fig. 1) taken by a division medical officer on the day prior to admission revealed bilateral pulmonary infiltrates.

The past medical history was noncontributory. The patient's father died of Bright's disease.

On physical examination he was seen to be a chronically ill white male in moderate respiratory distress. The respiratory rate was 25, temperature was 99 degrees F., and the blood pressure was 160/94 in both arms. The fundi revealed arteriolar tortuosity, but no hemorrhages or exudates were initially seen. The neck veins were slightly distended. There were a few crackling rales at both lung bases posteriorly. The cardiac border was percussed at the anterior axillary line, and the liver was palpable three fingerbreadths below the right costal margin.

\*Presented at the Interim Meeting of the Rhode Island Medical Society at the U.S. Naval Air Station, Quonset, Rhode Island, September 23, 1959.

Laboratory studies included: white blood cells 26,600 with a normal differential; hematocrit, 42; sedimentation rate, 28; urinalysis, specific gravity 1.010, 400 mgms. per cent of albumin, with 10 to 20 red cells and 10 to 15 white cells, with occasional granular casts. PPD and histoplasmin skin tests, liver function studies, serum electrolytes, serum calcium and phosphorus, and urine, sputum and blood cultures were all normal or negative. An Addis count revealed 4,000,000 red cells, 5,000,000 white cells and 100,000 granular casts. Urea and endogenous creatinine clearance studies were normal. Serum electrophoretic studies revealed a marked elevation of the Alpha-2 globulin. Urine electrophoresis showed 63 per cent albumin, 7 per cent Alpha 1 globulin and 10 per cent beta globulin.

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FIGURE 1

This X ray which prompted admission shows cardiac enlargement with diffuse bilateral pulmonary infiltrates which were subsequently shown to be pulmonary edema.



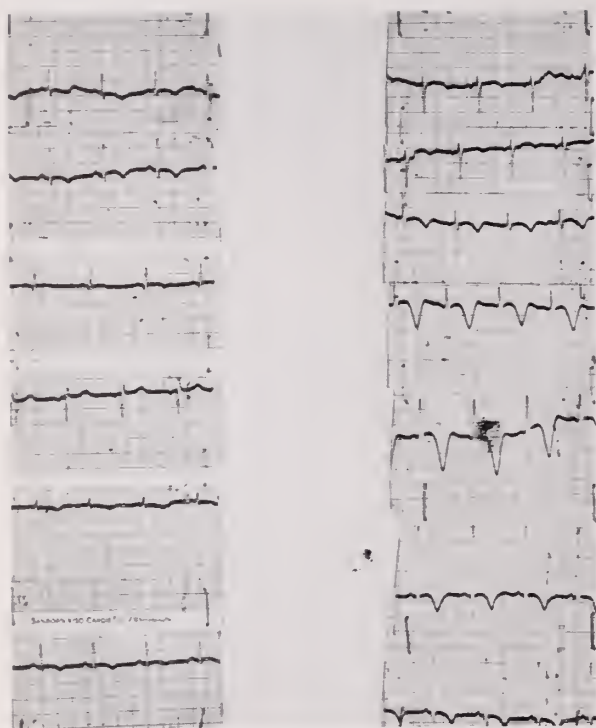


FIGURE 2

Electrocardiogram shortly after admission showing diffuse T-wave inversion compatible with pericarditis.



FIGURE 3

The intravenous pyelogram shows nonfunction of the left kidney.

Course in the hospital: Approximately 12 hours after admission the patient developed acute pulmonary edema which subsequently responded to routine cardiac measures. Serial electrocardiograms following this period showed diffuse ST and T wave changes compatible with acute pericarditis (Fig. 2). After digitalization the bilateral pulmonary infiltrates, which were radiographic counterparts of pulmonary edema, cleared. Shortly thereafter, the patient began to show evidence of a progressive galloping premalignant hypertension, with levels recorded up to 220/110. In a short period of two and one-half weeks following admission his eye grounds revealed Grade III hypertensive changes with numerous hemorrhages and exudates. These were not seen on admission. He showed concomitant progressive albuminuria and cylinduria. An I.V.P. revealed no function on the left side (Fig. 3). In order to clearly delineate the nature of the unilateral defect, an aortogram was performed under hypotensive conditions.<sup>3</sup> The right renal artery was adequately outlined, however no dye was seen in the left renal artery (Fig. 4). These findings confirmed the diagnosis of left renal artery obstruction. The patient was subsequently explored through a left flank incision utilizing hypobaric spinal anesthesia. The left kidney was studded throughout its cortical surface with numerous microabscesses. The left renal artery was almost but not quite completely occluded at a point approximately 1 cm from its origin by a firm white grey mural thrombus (Fig. 5). A left nephrectomy was performed. Following surgery, the patient showed an immediate therapeutic response as the blood pressure rapidly returned to a normal range of 120/80. In a period of three weeks the eye grounds showed almost complete resolution. The patient has been followed serially six months after surgery and has shown a complete return to normal in all parameters including the electrocardiogram and urine studies. Blood pressures continually run in the range of 110 to 120 over 75 to 80. The cardiopulmonary status is now stable (Fig. 6).

#### Comment

The basic disease entity in this patient appears to have been an idiopathic thrombosis of the left renal artery with secondary "renal hypertension." All of the auxiliary aspects of this patient's clinical picture were secondary features of the malignant hypertensive process. The origin of the acute pyelonephritis of the involved kidney was never clearly defined.

Much of the present clinical concept of the renal hypertensive syndrome is derived from the original work of Goldblatt<sup>4</sup> which reported that renal artery narrowing in the dog could cause hypertension. This experimental finding was subsequently implicated in human hypertension.<sup>5,6,7</sup> Finally the pio-





FIGURE 4

The aortogram shows adequate outline of the right renal artery and its major branches. The hepatic artery on the right and the splenic artery on the left are adequately outlined. The left renal artery is not outlined which indicates obstruction in that vessel.

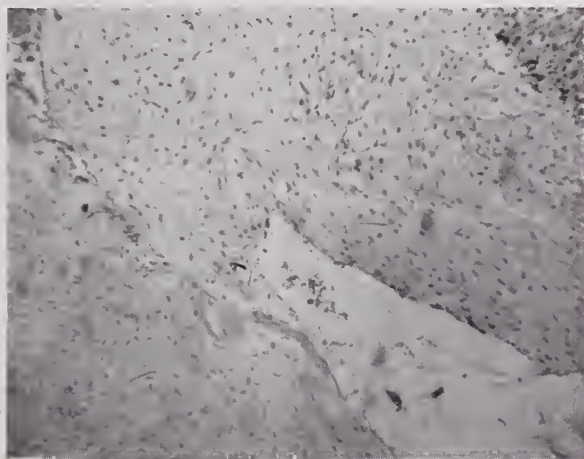


FIGURE 5

Microscopic section through the partially recanalized mural thrombus which incompletely occludes the left renal artery.

neering work of Page<sup>8</sup> and Braun Menendez on the renal pressor system served to further implicate the role of renal disease in human hypertension. The renal renin pressor system (Fig. 7) has been clearly implicated in experimental unilateral renal disease in animals, however its role in human hypertension associated with unilateral renal disease remains to be yet defined.<sup>1</sup>



FIGURE 6

Chest X ray one month following surgery showing return to normal of the cardiac silhouette and clear lung fields.

## ENZYMATIC SCHEME

Renin plus Renin Substrate

—————→ Angiotensin 1

Angiotensin 1-converting-enzyme →

Angiotensin 2

FIGURE 7

The renal pressor system. The proteolytic enzyme renin acts on a liver globulin "renin substrate" which in turn yields the decapeptide Angiotensin 1. The latter substance in the presence of plasma converting enzyme yields the octapeptide Angiotensin 2 which "causes" hypertension.

Human unilateral renal disease with hypertension has in the recent past captured the imagination of many clinicians due to the fact that it lends itself to a potential complete cure. Smith<sup>9</sup> in 1956 reviewed the literature up to that date and found 575 reported cases of human unilateral renal disease associated with hypertension. Only 25 per cent of these demonstrated adequate clinical cures following nephrectomy. A great factor behind this poor therapeutic result rate was undoubtedly the lack of

*concluded on page 821*

## TOTAL GLOSSECTOMY FOR CARCINOMA

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ALTHOUGH CARCINOMA of the tongue is relatively common and much has been written about its diagnosis and therapy, there is scant mention of total glossectomy in the treatment of this condition. A review of the literature revealed only three case reports and a paper on operative technique.<sup>1,2,3,4</sup>

### *Report of a Case*

#### *Rhode Island Hospital No. 424713*

J.C., an eighty-nine-year-old white male, was first seen in the Rhode Island Hospital Tumor Clinic in 1944 with a thirty-seven-year history suggestive of leukoplakia of the tongue. Physical examination revealed leukoplakia and an indurated area posteriorly. The entire tongue was deeply furrowed. His Wassermann was positive, he was a moderate cigar smoker.

Biopsy of the indurated area revealed a Grade One epidermoid carcinoma. Radium needles were inserted, and the patient received 2352 milligram hours of radiation.

He was followed in the Rhode Island Hospital Tumor Clinic for about sixteen months, and varying degrees of leukoplakia were noted.

In March 1946, sixteen months post-radiation, the patient was seen again; a generally thickened and markedly enlarged tongue with an ulceration on the left was noted. Scattered areas of leukoplakia

were still present (Figure 1). A few small, discrete lymph nodes were palpable in the left submandibular region. Surgical therapy was advised after biopsy again revealed Grade One epidermoid carcinoma.

In May 1946, a total glossectomy was performed through the submaxillary approach, as described by Kocher.<sup>5</sup> Exposure was adequate and the tongue base attachment was cleanly cut from the hyoid bone. Suggestions in technique from Vilray Blair's textbook<sup>6</sup> were found helpful. Immediate pathological examination of lymph nodes found in the operative field was negative for cancer. The post-operative course was uneventful.

Since that time, the patient has been carefully followed in the Rhode Island Hospital Tumor Clinic with no evidence of local or other recurrence. He has had no difficulty eating and has been able to talk fairly well (Figures 2 and 3).

### SUMMARY

1. A case of multiple Grade One epidermoid carcinoma of the tongue with associated leukoplakia has been presented.

2. The patient shows no evidence of recurrence thirteen years following total glossectomy.

3. Difficulty with eating and speech has been moderate.

*Note:* this patient was shown at the New England Cancer Society Annual Meeting, April 26, 1958, at



FIGURE 1  
Preoperative Appearance



FIGURE 2  
Present View to Show Scar

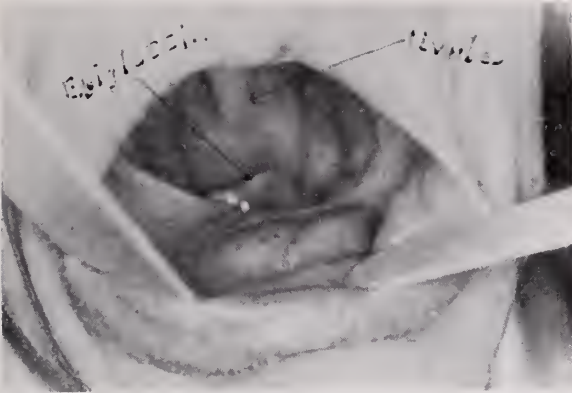


FIGURE 3  
Present View to Show Absence of Tongue

Providence, Rhode Island.  
*Note:* Examination in May 1959 revealed no evidence of recurrence.

REFERENCES

<sup>1</sup>Ashhurst: Excision of the entire tongue for carcinoma. *Ann. Surg.* 59:289, 1914  
<sup>2</sup>Ashhurst: On excision of the tongue. *Ann. Surg.* 62:238, 1915  
<sup>3</sup>Manson, J. S.: Cancer of tongue: excision of tongue: cancer of 34 years later. *Brit. Med. J.* 1:966, 1922  
<sup>4</sup>Torek, F.: Total extirpation of the tongue for carcinoma. *Medical Record* 86:653, 1914  
<sup>5</sup>Blair, V.; Moore, S.; Byars, L.: *Cancer of the face and mouth.* 599 pp. St. Louis: The C. V. Mosby Company, 1941

UNILATERAL RENAL DISEASE  
WITH HYPERTENSION

*concluded from page 819*

precise diagnosis in many of these cases. The relative frequency of unilateral renal disease in the general hypertensive population has been estimated to be anywhere from 2<sup>9</sup> to 25<sup>1</sup> per cent. This latter figure represents Page's results utilizing translumbar aortography in properly selected cases. Aortography had shed a modicum of light on the entire subject of unilateral renal disease, particularly renal arterial lesions, as was the situation in the patient reported in this case. Aortography when used in properly selected cases offers definitive aid in the diagnosis of unilateral renal vascular disease. The accepted indications include:<sup>1,3</sup> unexplained disparity in the size or function of the two kidneys as seen in intravenous pyelography; hypertensive young people without known cause; malignant hypertension in elderly patients particularly those with known arteriosclerosis; malignant hypertension of sudden onset in patients previously known to be normotensive; and patients with symptoms of previous renal infarction.

SUMMARY

The clinical entity of unilateral renal disease with curable secondary renal hypertension has been em-

phasized by the presentation of a case of a forty-two-year-old white male who developed premalignant hypertension in association with idiopathic left renal artery thrombosis. A clinical cure was achieved following nephrectomy.  
The relationship of the renal hypertensive syndrome to hypertension in general has been briefly discussed. The value of translumbar aortography in the diagnosis of unilateral renal vascular disease has been stressed.

Acknowledgment

I wish to acknowledge the assistance of Doctor Edward Ray, former urologist at the U.S. Naval Hospital, Newport, Rhode Island, who performed the surgery on this patient.

BIBLIOGRAPHY

<sup>1</sup>Dustan, H. P.; Page, I. H.; and Poutasse, E. F.: Renal hypertension. *N.E.J. Med.* 261:647, 1959  
<sup>2</sup>Page, I. H.; Dustan, H. P.; and Poutasse, E. F.: Mechanisms, diagnosis and treatment of hypertension of renal vascular origin. *Am. Int. Med.* 51:196, 1959  
<sup>3</sup>Poutasse, E. F.; and Dustan, H. P.: Arteriosclerosis and renal hypertension. *J.A.M.A.* 165:1521, 1957  
<sup>4</sup>Goldblatt, H.; Lynch, J.; Hurzal, R.; and Summerville, V.: Studies on experimental hypertension. *J. Exp. Med.* 59:347, 1934  
<sup>5</sup>Leadbetter, W. F.; and Barkland, C. E.: Hypertension in unilateral renal disease. *J. Urol.* 39:611, 1938  
<sup>6</sup>Leiter, L.: Unusual hypertensive renal disease. 1. Occlusion of renal arteries (Goldblatt hypertension). 2. Anomalies of urinary tract. *J.A.M.A.* 111:507, 1938  
<sup>7</sup>Freeman, G.; and Hartley, G.: Hypertension in a patient with solitary ischemic kidney. *J.A.M.A.* 111:1159, 1938  
<sup>8</sup>Schwarz, H.; Bumpus, F. M.; and Page, F. H.: Synthesis of a biologically active octapeptide similar to natural isoleucine angiotonin octapeptide. *J. Am. Chem. Soc.* 79:5697, 1957  
<sup>9</sup>Smith, H. W.: Unilateral nephrectomy in hypertensive disease: *J. Urol.* 76:685, 1956

HOSPITAL COSTS UP

The average cost per patient day in the nation's non-federal short-term hospitals has risen steadily in the postwar years, according to the American Hospital Association. Below is the average cost by year:

Year	Average Cost Per Patient Day
1949	\$14.33
1950	15.62
1951	16.77
1952	18.35
1953	19.95
1954	21.76
1955	23.12
1956	24.15
1957	26.02
1958	28.17



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# The RHODE ISLAND MEDICAL JOURNAL

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## YOUTH LOSES INTEREST

DESPITE THE GLAMOUR that has always surrounded the life of the doctor, and that has certainly been increased by the spectacular advances in surgery and the "wonder-working" medications that now are in daily use, a career in medicine appears to have less and less appeal to the young people of this country as the years go on. Is it perhaps that the equally remarkable achievements that are seen in other fields, notably in engineering and in other phases of applied science, have been successful in the competitive attempt to stimulate the imagination of American youth? Or is it perhaps that there is offered to the young graduate trained in applied science a position in industry that represents a much quicker and less costly road to a good financial return after a shorter and less grueling training period when compared with the years of hard work and the very high cost that are involved in the education and establishment in practice of a modern medical man. We are inclined to give great weight to the latter view.

That there are fewer students applying to medical schools, and particularly that those who do apply comprise a smaller percentage of college graduates of top academic grade can be fully documented. Data compiled by the Division of Operational Studies of the Association of American Medical Colleges and recently released bears this out. Some of these are as follows:

In 1950 5.1 per cent of college graduates applied for admission to medical schools, in 1958 the figure was 4.1 per cent, a decrease of almost 20 per cent.

Among the college graduates who applied in 1951, 40 per cent had achieved the grade of A in their previous year's work in college and 43 per cent had been graded B. In 1958 the figure for grade A students was 18 per cent and grade B students 60 per cent.

Withdrawals from medical school during the course have also increased both among students whose work had been below grade and those who had been doing well. In the academic year 1954-55, 5.5 per cent of the students withdrew as compared with 7.8 per cent in 1957-58.

It may be well to add that, as is well known, there are also other troubles which beset the medical schools. The report from which the above-mentioned data concerning the decreasing number and quality of applicants for medical education is quoted also contains the following information:

Twenty schools (12 tax-supported and 8 private) reported an average need of 50 additional faculty members to enable them fully to carry out their responsibilities. This, added to the average reported lack of 80 additional personnel (administrators, clerks and technicians, etc.), represents an approximate cost of \$500,000 per school. In 1953 a similar study indicated a dollar need of \$250,000 per school.

It is of interest also to note that despite the rise in tuition fees, the percentage of support to the average medical school from this source has fallen from 28 per cent in the year 1940-41 to 6 per cent in 1957-58.

What does it all mean? It indicates most certainly that the quality of American medicine of which we all have been justly proud is bound to deteriorate unless something is done. High-minded medicine has always tended to ignore the dollar sign but in this situation it cannot be ignored. The following statement is quoted from the report of the New England Board of Higher Education dated October 22, 1959, "although New England is the home of some of the world's greatest medical centers, the region does not compare favorably with the nation as a whole in the percentage of its residents entering medical school. Only Vermont has been above the national average during the past ten-year period

—it ranks fourth. It has the only *public medical school* in New England." (Rhode Island is 37th.)

The report goes on to state that a student in Vermont who receives a state scholarship can attend medical school for four years for \$1,400 as compared with \$4,000 to \$6,000 for residents of other New England states.

The implication is clear. If the citizens of the United States in general, and of New England in particular, wish to continue to receive the highest quality medical care and to lead the world in medical progress adequate support of medical schools and medical students must be forthcoming.

Alumni contributions, medical society collections and the like are proving inadequate. Whether by state or federal action, by the organized support of industry or by some other means, such support must be forthcoming — *OR ELSE!*

## McNAMARA HEARINGS ON AGED PROBLEMS

BY RESOLUTION the Senate established a subcommittee on Problems of the Aged and Aging under the auspices of the Senate Committee on Labor and Public Welfare. Senator Pat McNamara (D) of Michigan is the chairman of this subcommittee which was to

"examine, investigate, and make a complete study of any and all matters pertaining to the problems of the aging including, but not limited to, (a) a study of the major problems of the aged, (b) a study of the existing programs of agencies, both public and private, dealing with problems of the aged, (c) a study of the present role of the Federal Government in dealing with problems of the aged, and (d) a study of any additional Federal programs which should be undertaken to help solve the problems of the aged."

To carry out this many facet study the Committee was given \$85,000, and it was asked to make its report not later than January 1, 1960.

Thus we have a Congressional subcommittee formed to make a complete study of a problem that the Congress has already appropriated one and a half million dollars to secure through a White House Conference on Aging that will assemble in 1961. Why two studies, one by a special subcommittee of the Senate able to pick and choose its recommendations, and the other a nationwide survey with a national report stemming from individual state conferences at which studies of local conditions will be reported?

To make its "complete study" the McNamara committee held hearings in Washington on three

days last June. Twenty-one speakers were invited to appear before the committee; this group included one representative of the A.M.A., seven from college or university staffs, seven state, county or city health or welfare officials, three labor leaders, one representative of the insurance industry, and two from private or business agencies. The most demonstrative panelist to appear before the committee was Willbur Cohen, professor of social welfare at the University of Michigan, former technical adviser and director of research for the Social Security Administration.

A total of eleven hours and five minutes was consumed to hear the witnesses, most of whom presented prepared statements upon which they elaborated, and upon which the committee members asked few questions. The Washington hearings completed, Senator McNamara issued a short progress report to the Congress on September 10 in which he gave highlights of the hearings, utilizing to a great extent the testimony of Mr. Cohen.

Then the subcommittee took "to the road" presumably to get the grass roots opinions. The first stop was at Boston, where a two-day session was held at which 34 witnesses gave oral testimony, and a number of others submitted written testimony which was to have been made part of the record. There was little cross-examination.

Most astonishing was the fact that all the witnesses allowed to address the committee were representing *Massachusetts*, although the committee certainly should have been willing to hear something about the rest of New England. Mrs. Roberta Brown, administrator of the Rhode Island Division

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on Aging, was present to represent this state, and to convey at the same time a statement from Governor DelSesto. But not even five minutes was allowed for Rhode Island's bright story, and Mrs. Brown was told to take her chances with the microphone "when the audience is permitted to make comments from the floor."

A most interesting thing about the Boston hearings was the careful selection of witnesses holding government positions who were eager to plump for Federal legislation and to agree to Senator McNamara's suggestion that there should be a federal agency to supervise the problems of the aging population. Seymour Harris, economics professor at Harvard University, reiterated his oft-repeated line that there should be more dependence on taxes and less on insurance, and offered his endorsement of the principle of Forand-type legislation.

Its study of the northeast completed, and our \$85,000 tax money further depleted, the committee departed for Pittsburgh, where McNamara, leader of the band, would presumably again call the tunes.

### BOY SCOUTS' GOLDEN JUBILEE

When Narragansett Council, Boy Scouts of America, celebrates its golden jubilee in 1960, it will be interesting to note that a physician, Doctor Ray-

mond F. Hacking, now residing in Rumford, was enrolled as the first boy scout in Rhode Island.

The Scouting movement in Rhode Island, and near by Massachusetts embraced by Narragansett Council, has now grown from an idea to 541 units comprising 25,000 men and boys. Under the leadership of Chief J. Harold Williams the training of boys in this state has long been recognized nationally as the finest in the country.

Camp Yawgoog, New England's largest boys' camp, Champlin Reservation in Cranston for short-term camping throughout the year, and the recent additions of Aquapaug consisting of 250 acres on Worden Pond and Kelgrant, 225 acres on Narrow River, both in South County, are facilities to provide the youth of this state with unusual opportunities to engage in outdoor adventures.

Now in its Jubilee year, Narragansett Council, for the first time in its long history, is appealing to the public for funds to erect a centrally located year-round Scouting Service Center and Headquarters, and to enlarge, modernize and re-equip the great long-term camping facilities at Yawgoog and the other outposts.

Be a good scout, and help the campaign of Narragansett Council so that the boys of tomorrow may continue to enjoy the benefits of one of the finest youth programs in the nation.



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## MEDICAL CARE FOR WELFARE RECIPIENTS — STATE PROGRAMS

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A Summary Abstracted from Studies by Margaret Greenfield, Bureau of Public Administration, University of California, Berkeley  
(May, 1957 and September, 1958)

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### SUMMARY

**T**HIS MONOGRAPH describes the type of medical care that is available in continental United States to recipients of federally subsidized public assistance — the so-called categorical aid programs of old age assistance, aid to the blind, aid to dependent children, and aid to the permanently and totally disabled. Method of administration, scope of programs, financial provisions, and relationship with professional groups are given insofar as data were made available.

Information is derived chiefly from replies to questionnaires sent to the various states; also, in part on administrative manuals or regulations sent in by some states, and in part on a few published studies. The study should be read in light of the fact that use of a mail questionnaire for assembling information has its limitations. Questions may be interpreted differently by various respondents, replies may be misinterpreted by the analyst, and data do not always fall into hard and fast categories. There is always a time span, moreover, between filling out of questionnaires and publication of analyses.

States have been classified broadly according to the extent of participation by the state welfare agency (the health agency in one case) in responsibility for medical care of recipients of federally subsidized assistance. This was done for convenience of presentation rather than to set up a measure of evaluation.

Material of this type has particular relevance at a time when legislators and other interested groups may be reconsidering programs for medical care of welfare recipients in their states, with a view toward using to best advantage the federal matching funds for medical care made available by Congress to states with medical care plans.

The 1956 amendments to the public assistance titles of the Social Security Act provided that, beginning July 1, 1957, the federal government would pay half of total state expenditures — up to \$6 per month for each adult and \$3 for each child — for medical care in behalf of persons on the public assistance rolls. This amount was exclusively for payments to vendors of medical or remedial care or for insurance payments to cover such care.

In 1958 Congress again amended the public assistance titles of the Social Security Act. The special subsidy for vendor payments for medical care was removed but the maximum federal participation base for all the programs was raised so that the states could make payments for medical care either directly to the vendor or include them in the cash grant to the recipient.

### *Medical Care Primarily a Local Responsibility*

Before the 1956 amendments to the Social Security Act, medical care of public assistance recipients, as well as of recipients of general relief and of the medically indigent, was primarily a responsibility of the local community. In twenty-two states such care was financed partly through local taxes and partly through the voluntary free services of the medical and allied professions. In eleven states cost of a limited amount of care is shared by the state welfare department.

### *Sole Community Responsibility*

In ten states all medical care of welfare recipients, with the exception of mental health, control of tuberculosis and other communicable diseases, and crippled children's services, was solely the responsibility of the local community. These were *Arizona, Georgia, Idaho, Kentucky, Mississippi, Montana, South Carolina, South Dakota, Vermont* and *Wyoming*. One more state, *Tennessee*, also left medical care to the county although the State Department of Health administered a hospitalization program for needy persons who are acutely ill.

With the aid of the federal subsidy, statewide plans including practitioners' services and hospitalization, were set up in Wyoming for all federally aided recipients, and in Montana for the blind only.

### *Limited State Participation*

In eleven other states primary responsibility for medical care of the needy also rests with the local community but there is some state contribution.

*Arkansas* Department of Public Welfare provided a limited amount of hospitalization for acute or emergency cases, and also paid for nursing home care up to \$75 a month.

*California* Department of Social Welfare operated a remedial eye service program in aid to the blind. Department regulations also permitted inclu-

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sion in the cash grant of allowances for special needs, including medical care, up to the legislative maximum on the grant. In 1957 California set up a state program for the needy aged, blind and children which included physicians' home and office visits, drugs, emergency dental care, and complete dental care for children under thirteen years.

The only medical care paid for by the *Colorado* Department of Public Welfare was remedial eye service in the aid to blind program, and tuberculosis treatment for indigent patients. The federal subsidy led the state to contract with Blue Cross and Blue Shield for services to federally aided recipients.

*Delaware* Department of Public Welfare included medical care in the assistance standard as a basic living item at the rate of \$5 per month.

*Florida* Department of Public Welfare operated a limited hospitalization program for acute or emergency cases occurring in the categorical aid programs.

*Iowa* Department of Social Welfare ran a remedial eye treatment program and also paid for nursing care, dentists, and medical appliances.

*Maine* Division of Public Assistance provided hospitalization for federally aided recipients. Nursing home care was added with the federal subsidy.

*Nevada* State Welfare Department permitted verified medical care expenses in the old age assistance grant within the legal ceiling for the assistance payment. A limited amount of hospitalization was also provided for aged recipients through direct vendor payments. After the federal subsidy was made available, Nevada contracted with the State Medical Association for medical services for the aged and blind recipients.

*North Carolina* Department of Public Welfare supervised a county-administered hospitalization program.

*Oklahoma* Department of Public Welfare budgeted medicine, home nursing care, and nursing home care in the recipient's cash payment. Practitioners'

services and hospitalization were added after the federal subsidy.

In *Utah* the State Public Welfare Commission administered a program for prevention and treatment of blindness, and paid for dentures of needy recipients. This state also added physicians' services and hospitalization for all federally aided programs when the new subsidy became available.

#### *States with Total Medical Care Plans*

Before the 1956 Social Security Act amendments twenty-six states had set up broad medical care plans, either state administered or state supervised, which covered all categorical assistance recipients, and in some cases recipients of general assistance and the medically indigent as well. These states were:

Alabama, Connecticut, Illinois, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, RHODE ISLAND, Texas, Virginia, Washington, West Virginia, Wisconsin.

In twelve of these states most of the services judged to be optimum by public health experts were presumably present in the state program, but one limitation or another prevented classification of the plan among those that cover full medical needs of all recipients of public assistance.

Programs in the remaining fourteen states — *Connecticut, Illinois, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oregon, Pennsylvania, RHODE ISLAND, and Washington* — cover all categorical assistance recipients according to state standards and furnish reasonably comprehensive services, measured by the optimum yardstick set up by public health experts.

Cost schedules are established but quantity schedules, if any, may be exceeded with proper authorization when medically necessary. No ceilings are set upon expenditures for the individual recipient or for the particular assistance program. In three states — *New Hampshire, Oregon, and Washington* — the cost of total medical care must be within the funds available. This may also be the case in the other eleven states, but was not specifically stated to be so by respondents to the questionnaire.

The 1956 amendments enabled West Virginia to establish a comprehensive program within the limitations of the funds available. Indiana, Kansas, Louisiana, Ohio and Wisconsin also removed one or more limitations on services.

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#### **PROVIDENCE MEDICAL ASSOCIATION**

*113th Annual Meeting*

Monday, January 4, 1960, at 8:30 P.M.



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\*Ethan Allen Brown, N.E. J. Med., 223:843.

F. K. Albrecht, Mod. Mgmt. Clin. Med., P674,  
Williams & Wilkins.

F. W. Wittich, J. Am. Ger. Soc., 3:239, 1955



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## DISTRICT MEDICAL SOCIETY MEETINGS

### WASHINGTON COUNTY MEDICAL SOCIETY

The quarterly meeting of the Washington County Medical Society was held at the Dunes Club, Narragansett, Rhode Island, on Wednesday, July 8, 1959. The meeting was called to order by the president, Doctor Gordon Menzies, at 11:00 A.M.

*Unfinished Business:* It was suggested that the secretary write letters to all those who are improperly listed in the telephone directory as practicing a specialty. Criterion for proper listing is the *Roster of the Rhode Island Medical Society*.

The application of Doctor James Martin for membership in the Washington County Medical Society was read. It had been previously approved by the Board of Censors. It was moved by Doctor Jones to accept Doctor Martin's application and the motion was seconded by Doctor Manganaro. His application was therefore approved.

*New Business:* The public law in regard to driving while intoxicated was brought to the attention of the members and a copy of the law was circulated. There was then a motion to adjourn. Motion was made by Doctor Walsh and seconded by Doctor Jones.

*Scientific Section:* Doctor Charles J. Ashworth, Doctor Charles L. Farrell, and Mr. J. Lewis Eddy spoke on the Rhode Island Medical Society Physicians Service program.

*Members Present:* Doctors Burbelo, Capalbo, Farago, Gale, Hathaway, Linwood Johnson, Jones, Kraemer, Manganaro, McGrath, Menzies, McIver, Murray, Nestor, O'Brien, Ogden, Phelan, Pinto, Singer, Tully, Turco, Walsh, Tatum, and Latham.

Respectfully submitted,

NEIDA Q. OGDEN, M.D., *Secretary*

### PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, October 5, 1959. The meeting was called to order by the president, Doctor John C. Ham, at 8:30 P.M.

#### *Minutes of the Previous Meeting*

Doctor Ham noted that the minutes of the April meeting had been published in the RHODE ISLAND

MEDICAL JOURNAL and unless there was a correction to be noted they would stand approved as published. There were no corrections offered, and the minutes were approved.

#### *Report of the Secretary*

Doctor Michael DiMaio, secretary, reported that at a recent meeting the Executive Committee, in addition to its task of reviewing all applications for membership, took the following actions:

1. It voted to invite the board of examiners in medicine for the State of Rhode Island to meet with the Committee to discuss the subject of medical licensure in this state.

2. It reviewed a report from the Rhode Island Chapter of the National Foundation which included the notation that the Chapter will no longer pay physicians and surgeons fees, being of the opinion that the collection of a fee for a professional service should properly be a matter between the doctor and his patient.

3. It commended the Entertainment Committee for the outstanding golf tournament and annual dinner held at the Point Judith Country Club and Dunes Club on June 24.

4. It approved of the special listing in the classified section of the telephone directory of the availability of the Association's Medical Bureau to assist in securing a physician in an emergency.

5. It noted that the executive office had aided the Providence Fire Department in compiling information on the Rescue Squads for a story to be used in the JOURNAL OF THE A.M.A.

6. It commended the executive office for assisting in securing a more favorable postal rate in Providence for the mailing of laboratory specimens to the state health department.

#### *Applications for Membership*

The secretary reported that the Executive Committee had reviewed the applications for active membership of the following physicians and had recommended their applications for membership in the Association: Doctors Salvatore R. Allegra, Alesia Amodia, Albert A. Apshaga, John R. Bernardo, Jr., Simon L. Blumen, James B. Leach, Augustine M. McNamee, Kenneth B. Nanian, Zanonni Ortega, Clarence H. Soderberg, John R. Stuart, Joseph Tarantino, and John B. Thayer.

*Announcements of the President*

Doctor John C. Ham noted that five members of the Association had died since the meeting held in April, and he called upon the members to stand for a moment of silent prayer for Doctors Francis V. Garside, Frank A. Cummings, Andrew W. Mahoney, Montafix Houghton, and Herbert Armington.

\* \* \*

Doctor Ham called attention to the regional meeting of the American College of Physicians to be held in Providence October 23 and 24, and he extended an invitation to members of the Association to attend these sessions.

*Scientific Program*

Doctor Ham introduced Doctor Raymond Adams of Boston, Chief, Neurological Service and Neuropathology, Massachusetts General Hospital; Bulard Professor of Neuropathology, Harvard Medical School, who presented a clinical discussion of a case summary as follows:

*Rhode Island Hospital No. 599932*

White, female, married, age 71. First admission.

Since patient was unable to give a reliable history, most of the information was obtained from patient's husband and daughter.

She was admitted with chief complaints of disorientation and headaches of two weeks' duration. She is known to have suffered from persistent severe epigastric pain for the past three years, but she refused to be seen by a physician. One year ago she had a "spell" of vague description for which she rested in bed for a few days. For the past six to eight months her husband had noted that she had become progressively weaker, but he had not been aware of any paralysis or focal signs. For the past two months patient had suffered frequent episodes of amnesia, lasting only a few minutes, but accompanied by headache. A few days prior to admission she became obviously disoriented and restless. A physician was called, and she was admitted to the hospital.

System review was not too satisfactory, but it was noted that bowels had moved the morning of admission and had been regular except for some constipation during the past week. Persistent black stools were said to have been present for at least six to eight months, and there had been loss of weight and appetite.

Physical examination revealed an elderly female who appeared to be in acute distress, disoriented, and giving vague answers to questions. Her head was not remarkable. Pupils were equal and reacted promptly to light and accommodation. There was a probable slight ptosis of the left eye. No evidence of ocular paralysis. Ear, nose and throat examination

negative. Heart was not remarkable except for slow fibrillation, and lungs were negative. Blood pressure 156/84. Abdomen was distended. Liver and spleen not palpable. Rectal examination negative. Vagina atrophic. Extremities showed no edema; there were some varicose veins and a healed ulcer scar on the left leg. Neurological examination revealed the following: acute disorientation, absent reflexes of both lower extremities, bilateral Babinski and no evidence of hemiplegia.

Admission laboratory data as follows: Hemoglobin 16.4 grams, WBC 15,550, differential P/76, L/19, M/3, E/2, microhematocrit 52, fasting blood glucose 96 and blood urea nitrogen 15. A repeat WBC was 11,800. Oddly, no urine was recorded. Subsequent laboratory studies were as follows: prothrombin activity 91%, total protein 5.1 grams, serum albumen 3.2 grams, cephalin flocculation 0, repeat BUN 9, sedimentation rate 11.5 mm per hour, alkaline phosphatase 4.9. Repeat hematology on the eleventh hospital day yielded the following: Hemoglobin 14.0 grams, RBC 4.62, WBC 14,650, differential P/90, L/6, M/3, E/0, metamyelocyte/1, and microhematocrit 44. An initial stool examination gave a negative benzidine test for occult blood, a subsequent one showed a slight trace, but a third yielded a 4+ benzidine test. Four blood cultures were sterile. Tuberculin test (PPD) was negative. Initial chest X ray revealed no signs of pulmonary neoplastic disease; hilar shadows not remarkable; no effusion; normal cardiovascular shadow and normal diaphragm. X-ray films of the entire spine showed no evidence of primary or secondary neoplastic or other bone or joint pathology. Repeat chest X ray was also negative. EKG showed a grossly irregular rhythm due to flutter fibrillation. There was slight sagging of the ST segments to the left of the precordium. The electrocardiogram was considered abnormal because of the arrhythmia.

Previous to her admission to Rhode Island Hospital patient had been in Woonsocket Hospital, where the following additional studies were performed. Skull films negative. Barium enema negative. G.I. Series revealed a perforating gastric ulcer in the region of the gastric antrum on the lesser curvature. Three urines were essentially negative, one showing an occasional RBC. Sp.g. of one urine 1.021. Lumbar puncture yielded 5cc of clear fluid; total protein 164, globulin positive.

Neurosurgical consultant who examined patient shortly after admission noted that "patient is obtunded with forced grasping out; cerebral metastases are suspected."

Neurological consultant reviewed the history and noted progressive weakness, amnesia, mental decline, incontinence and confusion. He noted on examination gray hair with remnants of yellow dye.

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Patient had vacant look and spoke in a whisper so that much of her conversation was lost. She acted facetiously and, when asked to stick out her tongue, replied: "I don't want to be rude," and smiled with a broad toothless grin. She followed most simple commands. After much repetition she extended hands forward without much lateralizing drift. There was a grasping tendency, however, of the left hand. Cranial nerve examination was not remarkable except for constant tendency to ignore left visual field when presented bilateral stimuli. She perceived a single stimulus in the left visual field well. The pupils were equal and reactive. Fundi showed no optic disc swelling. There were occasional hyaline yellow flecks throughout the retina. Tendon reflexes in the upper extremities were slightly more active on the left than on the right, but no Hoffman sign was present. There was plantar withdrawal response and bilateral Babinski signs. Lack of co-operation precluded sensory examination. Language function, in particular comprehension, was depressed. She could not remember or concentrate and facetiously gave her age as 29. The neurological consultant concluded: "Neck questionably stiff in full antifixion. Carotid pulses equal in neck. Appears clinically like generalized cerebral disease and dementia, although right temporal or corpus callosum tumor is a definite possibility. Chronic meningitis secondary to torula is another possibility."

Lumbar puncture was performed on the third day and gave an initial pressure of 210. Cell count: RBC/1, Polys/1, and lymphs/37. Spinal fluid glucose was 23 and protein 145; smear and culture showed no organisms and culture for fungus was negative. EEG was unsatisfactory because of poor co-operation. There was slightly greater slow activity from the right hemisphere than from the left; but it was felt that this might be artefactual and not certainly of cerebral origin. On the seventh day a ventriculogram was performed under surital anaesthesia. On inserting the needles there was a gush of clear fluid from either side. Pneumoventriculogram showed moderate symmetrical dilatation of the lateral ventricles which were well filled with air. The third ventricle was demonstrated and was slightly dilated. Air was also visible in the spinal canal. Fourth ventricle was not demonstrated. There was no distortion or displacement of the air-filled ventricles and the findings were "apparently due to cortical atrophy."

### *Course in Hospital*

Patient was in the hospital a total of 28 days. During the first two weeks temperature rose daily to levels of 101 and 102 (rectal), during the third week it remained under 100, but during the final week it gradually rose again to levels of 103 (rectal). Pulse was 60-90 during the first three weeks

*continued on page 831*



## PROVIDENCE MEDICAL ASSOCIATION

*continued from page 830*

## A Summary of All Lumbar Punctures Follows

Hospital Day	IP	Color & Appearance	RBC	Polys	Lymphs	Glucose	Protein	Chloride	Smear	Culture	Acid Fast Smear	Acid Fast Culture	Fungus Culture
3	210	—	1	3	37	23	145	102	0	0	0	0	0
11	"normal"	clear	3	1	30	...	118		0	0	0	0	
18	200	clear	4	0	41	23	122						
19	—	clear	2	1	30	17	146	106	0	0	0	0	0

Remarks: "No Obstruction on Queckenstedt." Hinton negative.

but fluctuated to 120 during the final week. Respirations similarly rose from levels of 20 to 30, to 40 to 50 during the last seven days. There was no striking change in her condition during the initial three weeks. It was noted on one occasion that she was "dull and lethargic, responds incoherently and is difficult to rouse for food and drink." At other times she seemed brighter. Her course, however, was progressively downhill, and rapidly so during the fourth week. She was kept on Foley catheter drainage because of incontinence. At times Cheyne-Stokes respirations were noted. During the last week she became completely stuporous and unresponsive. She exhibited nuchal rigidity and her head was turned to the left. The house officer thought he detected a right hemiparesis but on the same day the nurses noted that the left arm was also slightly limp. There were no impressive changes in the vital signs. Toward the end patient developed a cough and respiration became labored. She expired quietly on the twenty-eighth day.

*Discussion by Doctors Adams and Williams*

Doctor Adams's discussion of the diagnostic possibilities was a masterpiece despite the fact that his final diagnosis did not coincide with the pathological findings as presented by the neuropathologist, Doctor Williams.

Doctor Adams' Diagnosis:

1. Carcinoma of the stomach with local metastases and metastases to the meninges.

Other possibilities:

1. Tuberculosis of the meninges.
2. Torula.

Doctor Harold W. Williams, Associate in Neuropathology; Chief, Department of Neurology and Psychiatry, Rhode Island Hospital, reviewed the pathology of the case as follows:

1. Tuberculous meningitis.
2. Tuberculous meningio-encephalopathy.
3. Tuberculosis of both adrenal glands.
4. Absence of pulmonary tuberculosis.

*Adjournment*

The meeting was adjourned at 10:15 P.M.

Collation was served.

Attendance was 91.

Respectfully submitted,

MICHAEL DiMAIO, M.D., *Secretary*

## PROVIDENCE MEDICAL ASSOCIATION

A meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, November 2, 1959. The meeting was called to order by the president, Doctor John C. Ham, at 8:30 P.M.

Doctor Ham stated that the minutes of the previous meeting would not be read unless there was a request for a reading. He stated that the minutes would be published in the RHODE ISLAND MEDICAL JOURNAL.

*Announcements by the President*

Doctor Ham called to the attention of the members that on November 10 the voters of Providence will go to the polls to give their approval or disapproval to three vital bond issues as follows:

1. \$4,600,000 for the city's share in the \$18,000,000 Fox Point Hurricane Dam.
2. \$1,000,000 for school modernization.
3. \$300,000 for improvements to the water purification plant in Scituate.

He noted that all these bond issues are important measures, and he urged the members to give them careful consideration and to take time to go to the polls to vote upon them.

Doctor Ham also called to the attention of the members the importance of the support by every member of the Benevolence Fund of the Rhode Island Medical Society, which seeks to aid physicians and their families.

He also noted that on October 31 Doctor Albert H. Miller, president of the Association in 1925, and one of the state's outstanding physicians, had died. The members present stood for a moment of prayer for Doctor Miller.

*Presentation of Membership Certificates*

Doctor Ham awarded membership certificates in the Association to those physicians elected to active membership at the October meeting.

*Report by Doctor William Reid*

The president called upon Doctor William Reid, delegate from the state Medical Society to the American Medical Association's Legislative Conference held in St. Louis in October. Doctor Reid reviewed the highlights of the Conference which he attended, and he informed the members present of

*concluded on next page*

the dangers present in the legislative proposals before the Congress to amend the Social Security Act to provide hospital and surgical benefits under a compulsory tax system.

*Panel on Physicians Service*

Doctor Ham introduced Doctor Charles J. Ashworth, president; Doctor Charles L. Farrell, secretary; Mr. J. Lewis Eddy, Director of Claims, and Mr. Stanley H. Saunders, executive director, of Physicians Service, each of whom discussed the operation of the Rhode Island Medical Society Physicians Service, reviewing in detail the program's development and the problems with which it is currently faced.

Following the formal presentation by the panel there was general discussion by the members present.

The meeting was adjourned at 11:15 P.M.

Collation was served.

Attendance was 118.

Respectfully submitted,

MICHAEL DiMAIO, M.D., *Secretary*

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*Regular Monthly Meeting*

Monday, February 1, 1960, at 8:30 P.M.

Panel Discussion on *Diabetes*

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### THROUGH THE MICROSCOPE

*continued from page 805*

including everything from chickenpox and sore throats to appendicitis and broken legs—are concentrated among children is documented in a report by the Public Health Service's National Health Survey, released recently.

The report discloses that during the year ending June 30, 1958:

—Young children suffered acute illnesses with twice the frequency of adults. The incidence rates for acute illnesses involving either restricted activity or medical attention ranged from a high of 4.0 occurrences a year for children under 5 to a low of 2.0 occurrences for adults 25 and over.

—On the other hand, adults over 25 averaged almost twice as many days of restricted activity from illness or injury as persons under 25. For different age groups under 25, the days of restricted activity per person per year ranged from 13.2 to 16.4, as compared with 24.1 days for adults over 25.

—Home accidents among children under 15 years of age were the chief cause of injuries restricting activity or requiring medical attention. They were an important cause, along with motor vehicle and work accidents, of restricted activity in the 15-24 age group.

The report also gives figures, for persons under 25, on impairments, limitation of activity and mobility due to chronic conditions, hospital discharges, physician visits, and dental visits.

The estimates are derived from interviews conducted for the National Health Survey by the United States Bureau of the Census with a representative sample of the civilian, non-institutional population. The information recorded about individuals is confidential and only statistical totals are published.

#### *Average Length of Hospital Stay Per Patient Declines*

Seven out of every ten persons admitted to hospitals stay seven days or less, the Health Insurance Institute reported recently.

Some 88% of all admissions stay 14 days or less and 96% stay 30 days or less, the Institute added in its report on a United States National Health Survey of hospitalization in the nation over a twelve-month period.

Several studies have indicated that the average length of hospital stay per patient has declined considerably in the post-war years. Programs of all health insurance organizations, said the Institute, have been expanded to meet the needs of modern hospital services.

A recent survey of 188 insurance companies disclosed that all provided policies with benefits for more than 30 days of hospitalization, and that 174 companies had policies with benefits for 90 days or

more, said the Institute.

More than 123 million Americans had hospital expense insurance at the end of 1958. Insurance companies, Blue Cross, and independent health care plans paid benefits of \$2.6 billion in 1958 for hospital care alone, out of a total of \$4.7 billion in health insurance benefits, said the Institute.

The National Health Survey revealed that women were hospitalized more frequently than men but stayed for a shorter period of time. Women were hospitalized at a rate of 123 per 1,000 to 74 per 1,000 among men, but stayed about seven days on the average to 11 days among men.

The higher rate of admission among women was attributed generally to maternity which probably also played a significant part in the surprising finding that the highest hospitalization rate by age group came in the 15-24 bracket where 137 out of every 1,000 experienced a hospitalization episode. The lowest rate was among children under 15 where 53 out of every 1,000 were hospitalized.

By region of the United States, the highest hospitalization rate was in the Midwest, where 105 of every 1,000 persons entered the hospital during the year. The West had a rate of 100, the Northeast followed with 97, and the South had the lowest, 95.

Of all admissions to the hospital during the year of the study, six out of 10 were surgically treated and four of 10 were not surgically treated. Surgical cases stayed, on the average, 7.5 days while non-surgical cases stayed 10.3 days.

The study showed that 99 out of every 1,000 persons in the United States were hospitalized during the year, and that they stayed in the hospital an average of 8.6 days.

#### *Great Increase in Graduate Medical Training*

A remarkable post World War II increase in graduate medical training programs for physicians is described in the 33d annual report on graduate medical education in the United States, prepared by the American Medical Association's Council on Medical Education and Hospitals.

The report's figures showed over 37,000 physicians taking graduate training in 1958-59. There has been a 50 per cent increase in available internships and a 500 per cent increase in residencies from 1941 to 1958.

The report, appearing in the October 10th A.M.A. Journal, attributed the marked expansion in the immediate postwar years to the desire of young physicians to secure specialty training after being discharged from military service.

Information in the report and an accompanying directory of approved internships and residencies help recent medical graduates plan further training, and aids administrators concerned with broad aspects of graduate medical training.

In 1941, there were 8,182 internships, the report

said. In 1958-59, there were 12,469, an increase of 2,271 over 1957-58. In 1941, there were 5,256 residencies. By 1958-59, this figure had increased to 31,818, up 6,842 over 1957-58. The number of hospitals offering training stood at 1,435 in 1958-59, an increase of 35.

The number of unfilled available internship positions remained at only 17 per cent. Sixteen per cent of the residency positions were unfilled compared to 18 per cent in 1957-58, the report added. It also stated that the average number of intern positions for each hospital is 14.6, the highest in the past ten years.

Internship positions mixed in several medical fields were 93 per cent filled; straight internships were 85 per cent filled. Rotating internships, which must include training on the medical, surgical, pediatric and obstetric services, were 83 per cent filled. As in previous years, straight internships in internal medicine showed the highest rate of occupancy — 88 per cent, the report said.

The report also showed:

— Nongovernmental hospitals offered 78.8 per cent of the available internships; federal hospitals, 4.5 per cent; nonfederal hospitals, 15.5 per cent, and private hospitals, 1 per cent.

— The highest occupancy rate, 93 per cent, was in federal hospitals. Private hospitals had the lowest rate, 75 per cent.

— Only 44 per cent of the positions offered in the Veterans Administration were filled. Internships in the uniformed services had almost 100 per cent occupancy.

— Hospitals in the New England area had 90 per cent of their internship positions filled on Sept. 1, 1958. As was true in past years, New Jersey, New York, and Pennsylvania are responsible for more than one-fourth of the internship training in the country.

In residencies by specialty, the report showed surgery offering the largest number of positions, followed by internal medicine. Psychiatry held third place.

These three plus pathology and obstetrics and gynecology accounted for approximately two-thirds of all the residency positions offered.

### *Thirty Days in Complete Isolation in Space*

Volunteer air force pilots have been carefully screened and a group selected from which two men will be drawn for the first U.S. experiment in long-term simulated space flight, it has been disclosed by Lt. Col. George R. Steinkamp.

Steinkamp, chief of the Department of Astroecology for the Air Force's School of Aviation Medicine, said plans are being made to confine two of the volunteers in a space cabin simulator, a seven-ton device, eight feet high and twelve feet long, for a period of thirty days.

*continued on next page*

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Despite the physical problems of living in cramped quarters for an extended period, Steinkamp said space medicine researchers expect the greatest stresses to be psychological.

"The men who enter the cabin," he said, "will be completely sealed off from the world to which they have grown so accustomed. Time will weigh heavily on their minds, and boredom will become their constant companion. The familiar day-night cycle they live by will be lost. Thirty days can be a very long time."

Steinkamp said the space cabin simulator is the first of its kind in the free world in which two men can live for as long as thirty days in complete isolation from the world, closely approximating conditions imposed by space travel.

As a result of developments at Minneapolis-Honeywell, the astronauts will breathe and re-breathe the same air and drink and re-drink the same water.

Starting with man's most basic need, pure breathing air, Honeywell designed and built an atmosphere control system with delicate sensing equipment to measure oxygen, carbon dioxide, nitrogen, and carbon monoxide.

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oxide through the use of chemical absorption beds, pumps in nitrogen if required and catalytically filters carbon monoxide.

Provision was even made for astronauts who might enjoy a smoke. The system includes a high voltage electrostatic filter to ionize and trap dust and smoke particles.

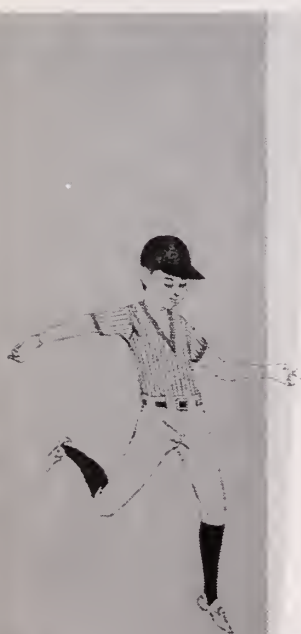
The space capsule is provided with heating and cooling elements for temperature control and a humidity control device that can pull moisture from the air and store it along with the water supply.

Food for the simulated trip will be non-perishable so refrigeration is not required, but a heating element will be provided to warm up soup and coffee.

The space capsule includes a panel with instruments which record environmental conditions and controls to alter these conditions. Also included are simulated space navigational controls for "flying" the capsule.

Information from the space capsule is piped outside to a highly instrumented console which will precisely record environmental conditions and occupant reaction for study by space medical researchers at Brooks Air Force Base.

Atmospheric controls for the cabin are designed so that either the occupants or researchers at the outside console can vary the pressurization, oxygen,



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### *Health Gains Greatest in Western World*

Health levels in the Western world are at an all-time high, Health Information Foundation reports. The average life expectancy in the United States, England, France, and Sweden, for example, is now about 70 years—an increase of 20 years since 1901.

Western countries have also shown remarkable progress in childbirth safety in this century. The maternal death rate is now only 4.1 per 10,000 live births in the United States, compared with 3.6 in Sweden, 4.8 in England, and 5.7 in France.

Deaths from communicable diseases have dropped sharply throughout the Western world in recent years. In the last three decades, for example, tuberculosis mortality has declined more than 90 per cent in the United States, England, and Sweden.

Since 1900, Health Information Foundation reports, death rates have been more than cut in half in four Western countries. In 1900, the average mortality rate for the United States, England, France, and Sweden was 17 per 1,000 population; by 1958 the rate had dropped to just over 7 per 1,000.

### *Two Decades of Crippled Children's Program Reviewed*

A review of the first twenty years of operation of the crippled children's program shows that the number of handicapped children served increased from an estimated 110,000 in 1937 to 313,000 in 1957, Mrs. Katherine B. Oettinger, chief of the Children's Bureau, has reported.

During this period, the rate per 1,000 child population served doubled from 2.4 in 1937 to 4.7 in 1957.

The program to serve crippled children is made possible through a State-Federal partnership established by the Social Security Act of 1935. Both the Federal and State governments contribute financially to its support. On the basis of their financial and medical resources, the states define crippling conditions they will accept for treatment. They operate the program through single state official agencies, utilizing hospitals and other treatment

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The Federal government, through the Children's Bureau, offers consultation to the states, collects facts about new treatment methods, assists states in serving more children and helps finance the training of workers who will serve handicapped children.

### *The Demand for Physicians' Services*

Our population growth will call for an increased supply of physicians according to a recent issue of *PATTERNS OF DISEASE*, prepared by Parke, Davis & Company for the medical profession.

In 1955, there were approximately 132 physicians per 100,000 persons in this country. However, it is estimated that our population will increase to such an extent by 1975 that the physician-population ratio will drop below that for 1955. To maintain this ratio, the equivalent of 20 new medical schools is needed, *PATTERNS* states. "Only in this way can the number of new physicians entering practice keep pace with expected population growth between 1955 and 1975."

Facilities for medical care vary from state to state, *PATTERNS* reveals. In general, facilities are most adequate in the northeastern states. Washington, D. C., Delaware and New York, respectively, have the greatest number of hospital beds available per 1,000 population and "of all states, New York

has the most favorable ratio" of physicians to population — 1 physician per 683 persons.

Women use physician services more frequently than men. Age too plays a role, with children under 5 and adults of both sexes in the older age group accounting for the highest number of physician visits.

Most visits take place in the physician's office, a survey described in the publication reveals. The survey showed that about two thirds of these took place in the physician's office as against about one ninth at the patient's home, and one tenth at the hospital clinic. Home visits were three times more frequent for patients in the older age group.

Most physician visits — about 70% — involve diagnosis and/or treatment. Of such visits, two thirds are related to chronic and one third to acute illness. General checkup accounts for about 10% of patient visits, immunization for about 7% and prenatal and postnatal care for about 4%.

When it comes to seeing patients, the general practitioner has the greatest national average daily patient load, averaging 18.5 patients a day. Second greatest load — about 17 per day — is carried by the pediatrician.

### *Hospital Facilities Widely Extended in Decade*

The number of people in the United States without ready access to general hospitals has dropped from 10 million to 2.8 million since 1948, the Public Health Service reported recently. Even in the most rural areas only a small percentage of the population is now without nearby hospital facilities.

This and other evidences of progress in hospital planning and construction, as well as needs for other types of health facilities, are shown in a new publication, *The Nation's Health Facilities—Ten Years of the Hill-Burton Hospital and Medical Facilities Program, 1946-1956*, issued by the Public Health Service. The report includes a summary of the program to January 1, 1958.

During the first ten years of the program, 3,047 projects were approved for construction. In addition to general hospitals, these new health facilities include homes, diagnostic and treatment centers, rehabilitation facilities, public health centers, and state health laboratories. Of the total cost of 2.5 billion dollars, the state and local share was nearly 1.7 billion. The remainder was provided by the federal government. States with the greatest need and the lowest income have received the most federal funds per person, the publication shows.



Lt. Col. George R. Steinkamp inspects the interior of the space cabin to be used for the first U.S. experiment in long-term simulated space flight. The seven-tone space cabin simulator, built by the Minneapolis-Honeywell Regulator Company, will soon be "home" for two Air Force volunteers for a thirty-day period.

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## BOOK REVIEWS

*A TEXTBOOK OF MEDICINE*. Edited by Russell L. Cecil, M.D., Sc.D., and Robert F. Loeb, M.D., Sc.D. Tenth Edition, W. B. Saunders Co., Phil., 1959. \$16.50

It has been the privilege of this reviewer to have the periodic opportunity of commenting upon the progress of medicine as reflected in the successive editions of this standard text. In this current edition, thirty-eight new articles have been added—some describing new entities, such as primary hyperaldosteronism, ECHO viral infections, and carcinoidosis, but mainly adding subjects which are now regarded by the editors as sufficiently important to warrant individual discussions. The latter include thrombotic thrombopenic purpura, cystic fibrosis of the pancreas, hepatic coma, and agammaglobulinemia.

Some sound advice on patient-physician communication is given in a nontechnical foreword by Doctor Dana W. Atchley.

This volume continues to hold its position as one of the two major American texts of medicine. The constant expansion of each edition, both in subject material and pagination, visibly documents contemporary increase in medical knowledge.

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- That 42 million wage earners were protected against loss of income by formal plans at the end of 1958.
- That an estimated one million Americans are confined to their homes because of chronic conditions affecting their health.

*SYNOPSIS OF TREATMENT OF ANORECTAL DISEASES* by Stuart T. Ross, M.D., F.A.C.S., F.I.C.S. The C. V. Mosby Co., St. Louis, 1959. \$6.50.

This book is the first treatise in manual form on this subject to appear in three decades and is a synopsis of treatment of anorectal diseases. The format permits easy and rapid access to information concerning the case at hand in the essentials of diagnosis and treatment.

The volume is an outgrowth of our times, streamlined and devoid of extraneous verbiage. The more complicated treatment of anorectal diseases the author, judiciously, leaves to the specialist.

The methods of diagnosis and treatment are based on those found effective in the author's experience. In many instances, the text is well illustrated.

The book was designed especially for the busy general practitioner. It should serve, also, as a guide for the medical student, the intern and the resident.

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113th ANNUAL MEETING

Monday, January 4, 1960, at 8:30 P.M.

"NUTRITIONAL FACTORS IN CARDIOVASCULAR DISEASE"

FREDERICK J. STARE, M.D.

*of Boston, Massachusetts*

Professor of Nutrition and chairman of the Department of Nutrition  
of the Harvard School of Public Health; Associate in Medicine at the  
Peter Bent Brigham Hospital

---

REGULAR MONTHLY MEETING

Monday, February 1, 1960, at 8:30 P.M.

PANEL DISCUSSION ON DIABETES

*Presented by*

SAMUEL B. BEASER, M.D.

LEO KRALL, M.D.

ALBERT RENOLD, M.D.

*all of Boston, Massachusetts*

LOUIS I. KRAMER, M.D.

*of Providence, Rhode Island*





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... THE EDITORS

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The menopausal patient in need of psychic support . . . the post-partum patient suffering the "baby blues" . . . the convalescent patient worried about her future health . . . these and many other patients will often benefit from the antidepressant, mood-lifting effect of

**Dexamyl**<sup>®</sup> Tablets • Elixir  
Spansule<sup>®</sup> brand of sustained release capsules

brand of dextro amphetamine plus amobarbital

When the depressed patient is particularly listless and lethargic, she will often benefit from the gentle stimulating effect of

**Dexedrine**<sup>®</sup> Tablets • Elixir • Spansule<sup>®</sup> capsules

brand of dextro amphetamine

 **Smith Kline & French Laboratories**















